Report Prepared By

Actuarial Services & Financial Modeling, Inc.

As Requested By

Anthem Blue Cross Life and Health Insurance Company

Regarding

Individual Rates to be Filed with the California Department of Insurance For April 1, 2011 Effective Dates (delayed to June 1, 2011)

Report Dated: February 23, 2011

By:

James P. Galasso, FSA, MAAA
President & Consulting Actuary
Actuarial Services & Financial Modeling, Inc.
333 Sandy Springs Circle, Suite 101
Atlanta, Georgia 30328

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I. GENERAL BACKGROUND AND SCOPE OF SERVICES

Actuarial Services & Financial Modeling, Inc. [dba Actuarial Modeling ("ActMod")] was engaged to assist the Anthem Blue Cross Life and Health Insurance Company ("Anthem"), by providing an actuarial review of certain individual health insurance rates developed by Anthem and filed with the California Department of Insurance ("CDI").

The policies affected by the rates subject to review consist of the twelve distinct Policy Form Groupings (the "Policy Forms") that are summarized in Section V of this report. Anthem prepared the rates assuming an effective date of April 1, 2011. This report (the "Report"), our actuarial analysis, and our actuarial opinions are based on this assumed effective date. We understand, however, that the actual rate changes may be delayed due to the regulatory rate filing process. Anthem submitted with the rate filing a trend adjustment factor to accommodate the actuarial adjustment needed should the assumed rate change effective date be delayed. To the extent this trend adjustment factor is applied consistent with the delayed effective date, the actuarial soundness for a revised projected period should be maintained (although the historical losses attributable to the delay would not be recouped by Anthem). Should the assumed effective date for the rate changes be delayed with no offsetting trend adjustment factor, the adverse impact on the actuarial soundness for the projection period is not reflected in this Report.

ActMod was asked to conduct an independent review of the methodologies and assumptions used by Anthem to establish rates for the Policy Forms. The Policy Forms sold after March 23, 2010impacted by the Rate Filing with benefits that comply with the federally enacted "Patient Protection and Affordable Care Act" and the "Health Care and Education Affordability Reconciliation Act of 2010" [collectively the Affordable Care Act ("ACA")] are referred to as Non-Grandfathered ("NGF") Plans.

The Policy Forms sold before March 23, 2010 impacted by the Rate Filing with the limited benefits required by ACA are referred to as Grandfathered ("GF") Plans.

James P. Galasso, President & Consulting Actuary for ActMod, a Fellow in the Society of Actuaries and a Member of the American Academy of Actuaries prepared this Report. Mr. Galasso has over thirty years' experience in actuarial work related to health care, has served as the Chief Actuary and Chief Financial Officer of large managed care organizations, and has provided actuarial consulting services to the health care industry. In these various capacities, Mr. Galasso has addressed the areas discussed in this Report on numerous occasions and meets the Qualification Standards for *Actuaries Issuing Statements of Actuarial Opinion in the United States* to issue the opinions contained herein. Mr. Galasso also meets the independence requirements stated in the California Insurance Code section 10181.6 (b)(3).

Mr. Galasso applied the appropriate actuarial standards in conducting his review of the actuarial methodologies and calculations used by Anthem to prepare the rate filing that is the subject of this Report (the "Rate Filing"). Mr. Galasso's curriculum vitae can be found as Attachment 1 to this Report.

The scope of our assignment included an independent review of the actuarial methodologies and assumptions used by Anthem to prepare the premium rates for the Policy Forms and the corresponding Actuarial Memorandum dated December 29, 2010 as amended February 2, 2011 (the "Actuarial Memo") and filed with the CDI that is the basis for the "Rate Filing". We were also asked to prepare this written report to address, to the best of our ability, the actuarial certification requirements described in a draft released by the CDI on February 3, 2011 regarding rate filing requirements for compliance with Senate Bill 1163 ("SB 1163 Draft Guidance").

SB 1163 Draft Guidance is included in this Report in its entirety as Attachment 22; Section VI of this Report summarizes the provisions and addresses compliance.

Please note that throughout this Report the definition of capitalized terms can generally be found in Section II ("Definitions and Industry Terminology").

Various files provided to ActMod by Anthem and discussed in this Report enabled us to reach the opinions presented in this Report.

The scope of this engagement included a detailed independent review of the files provided with respect to the accuracy, completeness, and methodologies as regards compliance with the SB 1163 Draft Guidance. ActMod approached this assignment by applying our best efforts to achieving these goals.

The estimates subject to review by this Report, of necessity, include projections of events that have not yet taken place (e.g. claims paid beyond the date for which information is available). While ActMod used accepted actuarial procedures in the review of these estimates, there can be no assurances that the ultimate actual projections will not differ materially from these estimates. In addition the accuracy of any estimates reviewed or discussed in this Report are dependent upon the availability and quality of the data received.

The detailed data (i.e. claim records, membership files, and premium receipts) that were required to prepare the Rate Filing were accepted as accurate and valid by ActMod without audit or detailed verification. Accordingly, ActMod is not able to provide assurances in this Report concerning the integrity of such information used in our analyses and on which our findings are based.

ActMod did review all data and information provided for general reasonableness. We have no reason to believe that any of the data or information provided is not accurate. Additionally, we believe our review addressed the appropriate issues and our conclusions presented herein are reasonable, given the information provided. From this point forward, the reader of this Report should assume that for certain data or information that we identified as having not been reviewed or audited by ActMod for other than general reasonableness (e.g. raw data and hard-coded data in electronic files provided), that we have no cause to believe that the information is not accurate.

Anthem was able and did provide all of the information requested by ActMod.

The scope of this engagement does not constitute a rendering by ActMod or its employees of any legal advice, and because our engagement is limited in nature and scope, it cannot be assumed to provide all analyses that may have importance to Anthem or others in this matter.

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Nothing included in this Report may be included in any filing with the Securities and Exchange Commission.

Any reader of this Report must possess a substantial level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions used in the analysis, and the impact of the assumptions on the illustrated results.

II. DEFINITIONS AND INDUSTRY TERMINOLOGY

A. Actuarial Values - (see Benefit Plan Relativities)

B. Adverse Selection - One of the most challenging issues that health insurance companies must contend with in a voluntary and competitive market is the ability of each prospective or current Member to forego health insurance or to select the benefit plan and insurance company that offers the most attractive alternative. Historically, health insurance companies have protected themselves from adverse selection attributable to new sales via the Medical Underwriting process (see Medical Underwriting). Controlling adverse selection attributable to enrolled Members is much more problematic. For example, when rate increases are necessary, every Member reassesses his or her current position. Healthy members are both more attractive to all competitors and less inclined to believe that the premiums they have been paying provide sufficient value. Accordingly, healthier members almost always have a higher Lapse Rate than less healthy members. In the absence of new sales offsetting this adverse selection phenomenon, the average PMPM claims cost for a Policy Form will increase above and beyond the myriad of other factors that also drive PMPM claims costs higher

   In addition to lapsing coverage or changing health insurance companies, when faced with premium increases, healthy members are also much more likely to replace their current health insurance policy with a policy with a lower Actuarial Value. Even if a healthy Member replaces his or her current policy with a lower cost policy from the same health insurance company, that company will still experience adverse selection. The adverse selection will be in the form of a reduction in the premiums received that exceeds the expected reduction in claims costs between the two policies.

C. Allowed Claims (or, Allowed Charges) – Allowed Claims represent the amount a health care provider bills a managed care organization **after** the application of contractual discounts negotiated with the managed care organization but **before** member cost sharing provisions are considered.

D. Anniversary Month – Individual health insurance Members generally receive rate changes on a regular basis (e.g. every 6-months or annually). The rate change month for a Member or collection of Members is usually called an "Anniversary Month", or a "Renewal Month".

E. Base Period (also referred to as Experience Period) – This is a term used by actuaries when they must project future medical costs and related data (e.g. members and premiums) for a defined purpose. The Base Period is derived from a recent subset of the Experience Data. The actuary often uses the Base Period to project future expected experience (e.g. for a defined Rating Period).

F. Benefit Plan Relativities (or, Actuarial Values) – When evaluating the historical and projecting the future financial experience for a defined group of Members, it is often necessary to adjust the experience for benefit plan changes that took place during the historical period. This requires an evaluation of the relative Actuarial Values for the benefit plans in effect during the historical period. These relative Actuarial Values are often referred to as Benefit Plan Relativities. For example when benefit plan A is expected to provide for benefit payments that, on average, amount to 90.0% of the expected benefit payments of benefit plan B, the Benefit Plan Relativity between plan A and plan B is 90.0%.

   Actuarial Value is also used to define the percentage of total claims costs that will be paid by a particular benefit plan. For example, a benefit plan with an Actuarial Value of 85% is expected to

cover 85% of total allowed claims costs with the Member paying for the remaining 15% in the form of Cost Sharing.

G. Billed Claims (or, Billed Charges) – Billed Claims represent the amount a health care provider bills a managed care organization **before** the application of contractual discounts negotiated with the managed care organization and **before** member cost sharing provisions are considered.

H. Claim Durational Factors – A phenomenon typical of individually underwritten health care policies, is the almost certainty that average PMPM claims costs will increase by Policy Duration due to Underwriting Wear-Off (see definition below). Claim Durational Factors are developed to measure the actual or expected claims cost PMPM for a given Policy Duration as compared to the corresponding claims cost PMPM for a defined normative Policy Duration.

   Medical Loss Ratio Durational Factors are often used In lieu of Claim Durational Factors. Analogous to Claim Durational Factors, Medical Loss Ratio Durational Factors compare the actual or expected Medical Loss Ratio for a given Policy Duration to the corresponding Medical Loss Ratio for a defined normative Policy Duration. This methodology has the benefit of capturing with a single factor the combined impact of both Claim and Premium Durational changes (see Premium Durational Factors below).

I. Cost Sharing – Cost Sharing refers to the amount of Allowed Charges that a Member must pay for health care services over and above that paid by a health care plan. The most common cost sharing provisions consist of deductibles, copayments, and coinsurance amounts. Benefit limitations such as lifetime or calendar year limits may also result in Cost Sharing.

J. Experience Data – This is a term used by actuaries to define the data (e.g. members, premium, and medical claims) that is often used for projection purposes. The data used for a defined Base Period is generally a subset of the Experience Data.

K. Lapse Rates – Lapse rates is an industry term used to measure the termination rate of members. The lapse rate is generally expressed as a monthly or annual percentage.

L. Managed Care Organization ("MCO") – Third party health care payers that negotiate contracts with health care providers to provide services to its Members are often referred to as Managed Care Organizations.

M. Medical Loss Ratio ("MLR") – While the subject of multiple definitions, in its most basic form (and, unless otherwise stated, as used in this Report) an MLR is defined as Incurred Medical Costs divided by Earned Premiums for a defined period of time.

N. Medical Trend (Claims Cost Trends, Claims Trend, or Claims Trend Factor) – The actual and/or expected change in claims cost (the claims costs are generally expressed on a Per Member Per Month, or "PMPM" basis) over a defined period of time (the change, or Medical Trend, is generally expressed as a percentage in annualized terms).

O. Medical Trend Leverage – The mathematical phenomenon that causes Medical Trends to be higher for benefit plans with fixed cost sharing provisions such as calendar year deductibles or fixed copays (e.g. all else being equal, a benefit plan will experience higher medical cost trends to the extent it has a fixed calendar year deductible that is higher than that of another similar benefit plan). This is due to the fixed cost sharing provisions offsetting a smaller proportion of a total benefit plan's claims cost as overall costs increase but the fixed cost sharing provisions remain fixed.

P. Medical Underwriting – The selection process that MCOs often use to review the medical history for a health insurance applicant. After reviewing an applicant's medical history, the MCO will generally assign the applicant to an Underwriting Tier.

Q. Member – Member is the term most commonly used to describe any participant in a health care plan, whether that participant be a Subscriber or a dependent of a Subscriber.

R. Member Months – The average number of Members covered during a defined time period multiplied by the number of months in that time period. Member Months is also used to describe the average number of Members covered for each day within a given month.

S. Months of Movement (also called "Trend Months") – This is a term used to measure the average number of months from the Base Period to the Rating Period. Months of Movement equals the number of months between the midpoint of the Base Period and the midpoint of the Rating Period.

T. Paid Claims - Unless otherwise stated this Report refers to Paid Claims as the amount a health care provider bills a managed care organization **after** the application of contractual discounts negotiated with the managed care organization and **after** member cost sharing provisions are considered. Paid Claims must often be distinguished from Incurred Claims but unless otherwise stated, this Report will use the terms Paid Claims and Incurred Claims interchangeably to distinguish them from Allowed Claims (see Definition above). Paid Claims generally refers to claims actual paid by a managed care organization. Incurred Claims refers to claims both paid and incurred but not yet paid (i.e. Paid Claims plus a liability estimate for claims incurred but not yet paid).

U. Per Member Per Month ("PMPM) – Dollar values in the managed care industry are often expressed on a Per Member Per Month ("PMPM") basis. For example, the average premium and or claims cost for Members for one month or for a series of months (such as the Experience Period or the Rating Period) are often expressed as a PMPM, which is calculated by dividing the total dollars for the period by the total number of Members that generated those dollars in the form of claims cost incurrals or premiums paid.

V. Policy Duration – The length of time (usually in years) since the issue date of a health care policy.

W. Policy Form – Policy Form is a term used to describe a health insurance contract that is filed with the appropriate regulatory authorities for a class of benefit plans offered to prospective and current Subscribers. A single Policy Form will often permit variations by benefit plan for certain defined items such as deductibles and other cost sharing provisions.

X. Premium Durational Factors – Premiums are often increased for member aging on an annual basis for individual health care policies. Therefore, premium PMPMs will generally increase by Policy Duration, even in the absence of premium rate table increases. This durational increase in premiums helps offset the increase in claims cost by Policy Duration (see Claim Durational Factors above).

Y. Rating Period – This is a term used by actuaries to define the time period for which future medical costs are to be projected for premium rating purposes.

Z. Risk-Based Capital – Most states have adopted the Risk-Based Capital ("RBC") model bill released by the National Association of Insurance Commissioners ("NAIC") that establishes minimum capital standards for health insurance companies and managed care organizations. For states that adopt the RBC Model Bill, various defined levels of capital precipitate various regulatory sanctions that reflect the deviation from minimum standards. For example, the basic measure that defines what is generally called the RBC Ratio is called the Authorized Control Level ("ACL"). When a company's capital falls below the ACL, a regulator is **authorized** to seize control of the company. When a company's capital falls below the Mandatory Control Level ("MCL"), a regulator is **required** to seize control of the company. No regulatory actions are generally required for companies that maintain their capital above the Company Action Level ("CAL").

   Strict regulatory sanctions, public and customer perceptions of companies subjected to RBC regulatory sanctions, and historically significant industry fluctuations in capital levels, are all strong incentives for companies to maintain their capital levels comfortably above minimum standards.

AA. Seasonality – This is the term used to describe the phenomenon that medical claims costs often vary by calendar month. This is especially true for benefit plans with high calendar year deductibles since claim payments for these plans are generally lower in the early months of a calendar year and increase in the latter months of a calendar year. That is, in the early months of a calendar year, a greater portion of claims are subject to the benefit plan deductibles that are the responsibility of the Member.

BB. Subscriber – This is a term that is often used to describe the purchaser of a health care policy. The health care policy itself may cover only the Subscriber (i.e. a "Single" policy) or the Subscriber and his or her dependents (i.e. a "Family" policy).

CC. Underlying Medical Trends – The portion of Medical Trends exclusive of the various factors that cause medical costs for a benefit plan to increase at a higher or lower rate than basic medical cost changes themselves (e.g. exclusive of Underwriting Wear-Off, policyholder aging, Medical Trend Leverage, benefit plan mix changes).

   It should be emphasized that theoretically "Underlying Medical Trends" should also exclude the impact of Adverse Selection. Unfortunately, it is often difficult to impossible to accurately measure the impact of Adverse Selection from the historical experience of a Policy Form without resorting to external sources for an estimate of Underlying Medical Trends. Accordingly, more often than not an analysis of Underlying Medical Trends from historical experience includes an element of Adverse Selection, which in the case of individually underwritten policies can be quite substantial.

DD. Underwriting Tier – An industry term used to define the classification of individuals after reviewing an applicant's medical history. Individuals will generally be assigned to a category such as "Preferred Risk", "Risk Category 1", Risk Category 2", through "not insurable". Some companies assign categories as expected percentages of a standard rate policy.

EE. Underwriting Wear-Off ("U/W wear-off") – Health care companies generally review and consider an applicant's medical history prior to issuing an individually underwritten health care policy (see Underwriting Tier). Accordingly, the claims costs and/or MLR of policies during the initial years following issuance can be expected to be materially lower than the claims costs and/or MLR for longer duration policies. That is, the policies remaining in force several years after issue often reflect several factors which cause their claims cost and/or MLR to be greater than that of more recently issued policies – even for policyholders of the same age and other demographic characteristics.

While Underwriting Wear-Off measures the wearing off of the original Medical Underwriting process, it does not adequately address the other elements discussed above that contribute substantially to Adverse Selection.

III. SUMMARY OF METHODOLOGIES USED FOR THE RATE FILING

Anthem constructed and followed several key methodologies that were used in the preparation of the Rate Filing. A summary description, followed by a detailed review, of each such methodology follows:

A. **Gathering of Detailed Data** – The first step in preparing a Rate Filing is to capture the relevant data at the appropriate level of detail to support the analysis required. Anthem captured substantial information for Membership, Premiums, Claims, and related information (e.g. data by Policy Duration, Benefit Plan information, Lapse Rate data, and Member Anniversary Months).

B. **Medical Trend Analysis** – Anthem developed the Medical Trend assumptions used in the Rate Filing by conducting a detailed trend analysis of the actual historical experience for each of the Policy Forms with credible historical data. Medical Trends are used to project medical costs from the Experience Period to the Rating Period. Medical Trend assumptions are also required to complete the Future and Lifetime MLRs required to comply with the California Code.

   (1) **Benefit Plan Relativity Analysis** - Anthem captured detailed claims and premium benefit relativity factors by benefit plan for the Policy Forms. Corresponding membership was also captured and evaluated. The member-weighted benefit plan relativities are used to normalize "Plan Mix" for the historical months for the Medical Trend analysis and for the LLR Model.

   (2) **Claim and Premium Durational Analysis** – Anthem developed both Claim Durational and Premium Durational Factors via a detailed historical analysis of the durational impact pattern demonstrated by the Policy Forms. Claim Durational Factors are required to adjust and analyze historical experience for developing the Medical Trend assumptions. Both Premium and Claim Durational Factors are used by Anthem's Lifetime Medical Loss Ratio Model (the "LLR Model") to demonstrate compliance with the California Code.

   (3) **Medical Trend Leverage Analysis** – Anthem evaluated and reflected Medical Trend Leverage Factors in the development of the Medical Trend estimates used for the Rate Development Process and the LLR Model.

C. **Seasonality Factor Analysis** – Anthem prepared a detailed analysis of the impact that Seasonality would have on monthly experience throughout a calendar year for each Policy Form. The Seasonality analysis is used by the LLR Model, which captures historical and projects claims experience on a month-by-month basis.

D. **Evaluation of Benefit Plan Changes** – The Rate Filing reflected benefit changes for:

   (1) ACA-mandated benefits (e.g. covering Preventive Services with no Member cost sharing and Guaranteed Issue for Children); and

   (2) Anthem proposed benefit reductions (e.g. proposed increases in Policy Form deductibles and coinsurance maximums, also referred to as out-of-pocket maximums).

   The impact of Benefit Plan changes are required to properly reflect projected claims costs for the Rating Period.

E. **Anniversary Month Analysis** – Anthem carefully captured and projected Members by Renewal or Anniversary Month for each Policy Form. The Membership distribution by Anniversary Month is important when estimating premium dollars for the Rating Period and when normalizing historical data for historical rate changes. Accordingly, the distribution by Anniversary Months is used by both the Rate Development Process and the LLR Model.

F. **Lapse Rate Analysis** – Anthem prepared a detailed analysis of Lapse Rates for the following three categories of Policy Forms:

(1) Monthly Lapse Rates for the Basic Hospital Plans Policy Form

(2) Monthly Lapse Rates for "Standard PPO" Policy Forms (i.e. SmartSense, PPO Share, Right Plan, Tonik, Lumenos w/ Maternity, PPO Saver, ClearProtection, CoreGuard, and Premier).

(3) Monthly Lapse Rates for the 3500 Deductible and Lumenos w/o Maternity Policy Forms

G. **Establishing a Rate Development Process** – Once Anthem captured and completed the required backup analysis, they applied what is often referred to as a "Rate Development Process". Anthem developed and followed a detailed Rate Development process to determine the rate changes proposed in the Rate Filing. In general, the Rate Development process begins with data summarized for the Experience Period and applies the appropriate adjustments (i.e. the items described above in this Section of the Report) to project the relevant parameters to the Rating Period, which includes the proposed rate changes. The Rate Development Process both develops the proposed rate changes and provides key inputs to Anthem's LLR Model.

H. **Preparing and Analyzing the LLR Model** – One of the final analytical steps for the Rate Filing involved populating and analyzing Anthem's LLR Model with the information noted above in this Section of the Report. The LLR Model develops the Future and Lifetime Medical MLRs that are used to demonstrate compliance with the California Code.

I. **Capture and Analyze the Reporting Requirements of SB 1163 Draft Guidance** – The final step for the purpose of preparing this Report involved capturing and documenting the various requirements of the SB 1163 Draft Guidance.

IV. DETAILS OF METHODOLOGIES USED FOR THE RATE FILING

Following is a detailed description of the process used by and the opinions reached by ActMod for each of the items summarized in Sections III. A. through I. above.

A. **Gathering of Detailed Data** – Anthem gathered the data necessary to prepare the Rate Filing. The details of the data captured and used are described in the below discussion of the various methodologies. As previously noted, the Rate Filing had an original proposed effective date of April 1, 2011. Anthem prepared the Rate Filing with information available that permitted a filing with what was believed sufficient time for an adequate regulatory review. Specifically, claims payment and premium data was available through September 30, 2010.

Since claim incurral analysis requires a review of claims payments made beyond the actual date of incurral, Anthem used the claim incurrals through June 30, 2010 with claim payments through September 30, 2010.

Since the Rate Filing review processed has been delayed, the current analysis includes premium data through November 30, 2010. This enabled Anthem to properly reflect the premiums for rate changes effective October 1, 2010 that were originally planned for March 1, 2010.

ActMod believes that Anthem requested and used the appropriate data required to prepare the Rate Filings consistent with sound actuarial practices and principles.

B. **Medical Trend Analysis** – Medical Trend Factors are critical to the development of actuarially sound projections for medical costs and medical loss ratios. Anthem identified various components of the Medical Trend Factors in order to develop estimates for the Underlying Medical Trend factors that were used by Anthem's Rate Development Process and its Lifetime Medical Loss Ratio Model. Given the difficulty of removing the impact of Adverse Selection with respect estimating Underlying Medical Trends, ActMod believes the Underlying Medical Trends discussed in this Report include Adverse Selection as a substantial component.

Fifty-seven months of Experience Data for incurred claims and membership from January 2006 through September 2010 was used for the Medical Trend analysis period.

Anthem specifically considered and adjusted for the factors noted below in their trend analysis:

(1) **Benefit Plan Relativity Analysis**. The Rate Filing impacts the 49 Benefit Plans shown in Attachment 3. Each of the 12 Policy Forms noted in Attachment 3 consists of several benefit plans (labeled "Contract Description" in Attachment 3); except the "PPO SAVER" Policy Form that consists of only one benefit plan. Member movement within a Policy Form but across benefit plans need to be normalized for each month of the historical Medical Trend analysis period when measuring historical Medical Trends. Anthem uses the "Claims" column in Attachment 3, weighted by member months, for this normalization process and refers to this as a "Plan Mix" Adjustment.

In analyzing Medical Trends, Anthem determined what, if any, Benefit Plans have been revised at any time during the Medical Trend analysis period. The only benefit revision during the fifty-seven month analysis period was an 8.7% reduction in benefits for the Tonic benefit plans that was effective March 1, 2008. Anthem made the appropriate adjustments for the months impacted by this benefit change. The period actually used to establish Medical Trends (i.e. the 24 month period ending June 30, 2010) was not impacted at all by the 8.7% benefit revision.

As noted in a footnote on Attachment 3, maternity claims were removed from the Claims Factor analysis. The actuarial rationale for removing maternity costs was attributable to the fact that individuals moving from a product covering maternity to a product not covering maternity (the general direction for these product offerings) do so with the knowledge that they are unlikely to incur medical costs due to maternity. Thus, there is little to no actual impact on the underlying costs attributable to this movement (i.e. maternity costs are negligible for these individuals). ActMod concurs that this is an appropriate and actuarially sound adjustment.

ActMod reviewed these Claims Factors for directional reasonableness and found them to be reasonable. For the detailed factor analysis, we relied on the analysis performed by the Anthem actuary identified in the Actuarial Reliance Certification (Attachment 2).

(2) **Claim and Premium Durational Analysis** - Claim Durational Factors are used both for the Medical Trend Analysis and the LLR Model. The Claim Durational Factors used for this Rate Filing by Policy Form are, with one exception, identical to those used in the LLR Models filed with the CDI in prior rate filings as documented by the Actuarial Memorandums dated August 3, 2010 and a series of Actuarial Memorandums by Policy Form (eight in total) each dated June 30, 2010. Axene Health Partners ("AHP") reviewed each of these filings on behalf of the CDI and found the Claim Durational Factors to be reasonable.

The Claim Durational Factors are shown in Attachment 5.

The one Policy Form exception with respect to a change from prior rate filings as regards the Claim Durational Factors was for the 3500 Deductible Policy Form. For this Policy Form, Anthem developed a new set of factors with a lesser slope than the previous set of factors.

ActMod tested the impact of the change in the Claims Durational Factor on both the LLR Model results and the Medical Trends.

The impact of the lesser slope, as described in the below description for the LLR Model and displayed in Attachment 6, is to lower the Future and Lifetime Medical Loss Ratios and thus make it more challenging for Anthem to meet the minimum medical loss ratio requirements of the California Code.

Had the older Claim Durational Factors for the 3500 Plans been used for the Medical Trend analysis, the Measured Medical Trend for the 3500 Plans would have decreased from the 16.9% shown in Attachment 8 to 14.4%. The total composite Measured Medical Trend for all Policy Forms would have decreased an immaterial amount from the 19.8% shown in Attachment 8 to 19.5%. Even if the old Claim Durational Factor for the 3500 Plan had been used, Anthem indicated that they would not have changed the rounded 17.0% composite Medical Trend assumption used for the Rate Filing as also shown in Attachment 8.

While not used for Medical Trend analysis, the Premium Durational Factors are calculated in conjunction with the Claim Durational Factors. The Premium Durational Factors are used by the LLR Model and, for this Rate Filing, are identical, without exception, to those used in the LLR Models filed with the CDI in prior rate filings as documented by the Actuarial Memorandums dated August 3, 2010 and a series of Actuarial Memorandums by Policy Form (eight in total) each dated June 30, 2010. Axene Health Partners ("AHP") reviewed each of these filings on behalf of the CDI and found the Premium Durational Factors to be reasonable.

Given the complexity of calculating Premium and Claim Durational Factors, Anthem does not generally update these factors more than once per year.

(3) **Medical Trend Leverage Analysis** - Anthem analyzed the impact of deductible leveraging by Policy Form as follows:

(a) Anthem used Milliman Health Cost Guidelines to develop Policy Form-specific leveraging factors for medical care costs exclusive of prescription drugs. Milliman is a large nationally recognized actuarial consulting firm with substantial expertise in health care. ActMod believes that Milliman's Health Cost Guidelines is the most prevalent source of actuarial data used by most large and small managed care organizations.

(b) Anthem conducted its own analysis to estimate the leveraging impact of the fixed cost sharing benefit provisions for prescription drug expenses.

(c) Anthem then developed a composite weighting of medical costs and prescription drugs to estimate the total impact of Medical Trend Leverage Factors for each Policy Form.

(4) The results of the above Medical Trend Analysis is presented in Attachment 8:

(a) Column (1) presents the measured trend adjusted for all of the factors noted above.

(b) Column (2) shows the Medical Trend Leveraging Factor for each Policy Form.

(c) Column (3) removes the Medical Trend Leveraging Factor assumed in the measured trend.

(d) Column (4) develops Policy Form-specific Medical Trends that composite to the total measured trend; but each Policy Form-specific Medical Trend reflects only the Policy Form-specific Medical Leveraging Factor.

(e) Column (5) maintains the same relationship across Policy Forms as that developed in Column (4) but reduces them such that they composite to an Anthem-assumed trend level of 17.0% versus the measured composite trend level of 19.8%, or approximately 14% less than the measured composite trend (i.e. 17.0 / 19.8 – 1.0).

In discussing this adjustment with Anthem, ActMod was advised that the adjustment reflected what appears to be a mitigation of medical trends that the health care industry experienced in 2010.

There are various opinions as to what may have caused the lessening of medical trends during 2010. ActMod attributes the change to the severe recession and the corresponding delay in opting for discretionary medical services. It is an open question as to whether this trend will continue or reverse during the 2011 calendar year. ActMod is concerned that the widespread implementation of covering preventive services at 100% will accelerate demand for medical services. It is also possible that the pent up demand for discretionary medical services will be released in the coming months further driving up Medical Trends.

(f) Medical Trend assumptions for the three Policy Forms without credible historical experience (i.e. ClearProtection, CoreGuard, and Premier) were set equal to the composite average for all other Policy Forms combined [see Column (3)], adjusted for their own Medical Trend Leverage Factors.

(5) In addition to the above factors that may impact Medical Trend, ActMod requested that Anthem provide information regarding the potential impact that shifts in Membership by Geographic Area and/or Underwriting Tier may have on Medical Trends. Attachment 9 shows the rolling 12-month changes in both the Geographic Area Factor and the Underwriting Tier Factor for the 12-month periods ending March 2010 and May 2010, respectively. As can be seen in Attachment 9, the changes for rolling 12-month periods is extremely stable with variations between a positive 0.1% and a negative 0.3%. We believe that such minor changes are immaterial to the Medical Trend estimation process.

(6) As previously mentioned, the Medical Trends shown in Attachment 8 reflect a significant amount of Adverse Selection that is not measured by estimating the Underwriting Wear-Off of the original Medical Underwriting process. Anthem has estimated the actual Underlying Medical Trend as 8.9%, which suggests that Adverse Selection is contributing about 8 percentage points to the estimated composite assumed Medical Trend of 17.0%.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the Medical Trend Factors and believe they are actuarially sound and the assumptions reasonable.

C. **Seasonality Factor Analysis** – Seasonality can be an important consideration with respect to establishing the initial and subsequent monthly assumptions for Anthem's LLR Model. Anthem developed its Seasonality Factors as follows:

(1) Anthem used a prior study based on detailed month-by-month membership, Paid Claims, and Allowed Claims for the 24-month period ending December 31, 2009 with claim payment data through March 31, 2010. This same study was used for prior filings with the CDI that was reviewed by AHP and found to be reasonable. Given the relative stability of Seasonality Factors, Anthem updates this study on a periodic basis. The study included data for eight of the twelve Policy Forms included in the Rate Filing (i.e. all Policy Forms other than Basic Hospital, ClearProtection, CoreGuard, and Premier).

(2) Anthem developed trend adjusted monthly Allowed Claims PMPMs for the 12-months for the 2009 calendar year.

(3) Anthem next developed monthly Seasonality Factors for the Allowed Claims and normalized the Seasonality Factors such that they composited to 12.0 for a calendar year.

(4) Anthem next developed monthly Seasonality Factors for Paid Claims attributable to both Deductibles and factors unrelated to Deductibles. This involved first measuring monthly Seasonality Factors for Paid Claims grossed up to the level of Allowed Claims and then applying the Allowed Seasonality Factors from item (3) above. For each step in the process Anthem normalized all monthly factors such that they composited to 12.0 for the calendar year.

(5) Finally, the Seasonality Factors are aggregated by Benefit Plan for the Policy Forms in the Rate Filing.

(6) The SmartSense Seasonality Factors were used for each of the Policy Forms noted in item (1) for which data was not specifically evaluated.

(7) Attachment 10 displays the Seasonality Factors resulting from the above analysis.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the Seasonality Factors and believe they are actuarially sound and the assumptions reasonable.

D. **Evaluation of Benefit Plan Changes** – The Rate Filing included the following two types of benefit changes:

(1) ACA-mandated benefits are further broken into the following two sub-segments:

(a) Grandfathered ("GF") Benefit Plans (i.e. Benefit Plans that were sold prior to the passage of ACA on 3/23/2010) received the following benefit enhancements:

(1) Dependent eligibility to the age of 26

(2) Removal of lifetime benefit limits

(3) Removal of annual benefit limits

(b) Non-Grandfathered ("NGF") Benefit Plans (i.e. Benefit Plans that were sold on or after the passage of ACA on 3/23/2010) received the following benefit enhancements:

(1) All of the above GF benefit enhancements

(2) Preventive Care benefits covered at 100% (i.e. no Member cost sharing)

(3) Guaranteed Issued for children to age 19

In conjunction with information provided by Anthem's certifying actuary (Attachment 2), ActMod reviewed much of the analysis with respect to the pricing of the ACA-mandated benefits. ActMod believes the estimated costs for certain items may slightly understate the ultimate impact.

For example, Anthem decided to not include any charge for eliminating lifetime maximums, eliminating annual maximums, and covering dependent children up to the age of 26. While we concur with Anthem that the cost for these items will likely be modest, they will be some positive amount. In fact, Anthem assumed that the cost of eliminating annual maximums alone will be approximately 0.5%.

We should also note that the pricing for the ACA benefits was included in a prior rate filing documented by the Actuarial Memorandum dated August 3, 2010. This prior rate filing was reviewed by AHP and found to be reasonable. The only difference in the pricing of the ACA benefits between this prior rate filing and this Rate Filing, is that for this Rate Filing the proposed rate change attributable to the Guaranteed Issue for Children provision was reduced by 50% since the affected Policy Forms have been closed effective 9/23/2010.

The details of the cost estimates by Policy Form are shown in Attachment 11.

While ActMod believes Anthem's pricing of the ACA Mandated Benefits is somewhat aggressive (i.e. the additional cost, in our opinion, is more likely than not to exceed the price charged), we do not find Anthem's methodology and ultimate assumptions unreasonable and they do benefit Anthem's Members. Accordingly, we believe that Anthem's methodology and assumptions are actuarially sound.

(2) "Other Benefit Changes" were proposed by Anthem in an effort to mitigate the proposed rate increases.

The Anthem proposed benefit reductions did not affect five of the twelve Policy Forms in the Rate Filing. Not affected were the PPO Saver, Basic Hospital Plans, ClearProtection, CoreGuard, and Premier Policy Forms.

A summary description of the proposed benefit changes and the corresponding proposed rate changes are shown in Attachment 12.

ActMod reviewed the summary analysis prepared by Anthem regarding the pricing of the proposed benefit reductions. This summary analysis consisted of a test comparison between the results of Anthem's proprietary pricing for a representative sample of the benefit plan changes and a corresponding analysis based on a medical cost continuance table from the Milliman 2008 Health Cost Guidelines. This test comparison showed negligible differences between the analyses (i.e. a 0.3% differential for one test and a 0.1% differential for a second test).

Based on our review of the above information and our reliance on the more detailed pricing analysis prepared by the certifying actuary noted in Attachment 2, ActMod believes the pricing for these proposed benefit reductions is actuarially sound and the assumptions reasonable.

E. **Anniversary Month Analysis** – Properly reflecting rate change anniversary months for this Rate Filing required that careful attention be paid to the impact of the regulatory delay in the proposed rate increases originally planned for March 2010 that were delayed until October 2010. Members who would have normally received their increases between March 2010 and September 2010 received their increases in October 2010. The Rate Development Process for this Rate Filing assumes that the rate changes proposed would occur 6 months after a Member's prior rate change date.

For example, Members who received an increase in October 2010 would receive the increase proposed in this Rate Filing on April 1, 2011 and April would become the new Anniversary Month for these Members. Members who last received an increase in November 2010, would receive the increase proposed in this Rate Filing on May 1, 2011 and May would become the new Anniversary Month for these Members. Once all Members passed through this one-time six month cycle, the Rate Filing assumes that all Members would revert to receiving their increases every 12 months.

Of course, to the extent Members had contractual rate guarantees, such guarantees would be honored by Anthem.

To the extent the proposed rate change dates are delayed, the Rate Filing assumes that Anthem will increase rates for each Policy Form by the one-month composite trend factor of 1.3% $[(1.17)^{(1/12)} -1.0]$ for each month of delay. This adjustment will maintain the actuarial soundness integrity of the rate filing on a going forward basis, but will not compensate Anthem for the lost revenues occurred during the delay.

The Member distribution by Anniversary Month and Policy Form for the Rate Development Process and the LLR Model are shown in Attachment 13.

Anthem carefully considered the impact on Anniversary Months and, in our opinion, reflected the impact in an actuarially sound manner.

F. **Lapse Rate Analysis** - Anthem used a prior study based on Member lapse rates for the months of May 2008 through May 2009 for Policy Duration months 1 through 73 or later. This same study was used for prior filings with the CDI that was reviewed by AHP and found to be reasonable and actuarially sound. Anthem updates this study on a periodic basis. The results of the study are displayed in Attachment 4. The lapse rate assumptions by Policy Duration month are shown for each of the 12 Policy Forms in the Rate Filing. The lapse rates shown are used by the LLR Model.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the Lapse Rate Analysis and believe they are actuarially sound and the assumptions reasonable.

G. **Establishing a Rate Development Process** – A Rate Development Process involves the integration of many of the assumptions discussed in Sections IV. A. through F. above into a comprehensive analysis that progresses from the summary of basic data for a defined Experience Period through the development of actual premium rates, required rate changes, and/or proposed rate changes.

Anthem selected the time periods July 1, 2009 through June 30, 2010 and April 1, 2011 through February 28, 2013 as the Experience Period and Rating Period, respectively for the Rate Development Process.) The steps Anthem followed for this Rate Filing are shown on Attachments 14A and 14B and consist of the following (note the below numbered sections correspond to the numbered rows on Attachments 14A and 14B):

(1) Member months are captured for the Experience Period.

(2) Actual Premium Dollars are captured for the Experience Period.

(3) Incurred Claim estimates are captured for the Experience Period (Note: "Incurred Claims" are always considered estimates since they always include some estimate for claims incurred but not yet paid – even if that estimate is zero). Anthem's estimates are very credible since they include three months of run-out data (i.e. paid claims through September 30, 2010).

(4) Current Loss Ratio = Step (3) / (2)

(5) Current Claims PMPM = Step (3) / (1)

(6) Adjusted Claims PMPM; this are identical to Step (5) with the exception of the immature CoreGuard and Premier Policy Forms that did not have credible historical experience. For these two Policy Forms, Anthem used the SmartSense experience adjusted for the benefit differences and other items noted on Attachment 14B.

(7) Midpoint of Experience Period; this is calculated as the Member-weighted midpoint of the Experience Period.

(8) Premium at Current Rates PMPM; these PMPMs adjust the Actual Experience Period Premium for current rates, the Premium Durational Factors, and the Plan Mix Premium Factors.

(9) Annual Claims Trend; for the period of time between the midpoint of the Experience Period through December 31, 2010, the Medical Trends shown in Attachment 8 are applied; the Medical Trend for months beyond December 31, 2010 are reduced consistent with the declining Medical Trend assumptions used by the LLR Model.

(10) Midpoint of Rating Period; this is calculated by weighting the Member Months during the Rating Period with the proportion of Members projected to receive the proposed rate change for each month during the Rating Period.

(11) Months of Trend; this is calculated as the number of months between the Midpoint of the Experience Period [Step (7)] and the Midpoint of the Rating Period [Step (10)].

(12) Change in Claims Duration Factor; this is the change in the Member-weighted Claims Duration Factor (from Attachment 5) between the Experience Period and the Rating Period.

(13) Change in Plan Mix Factor (Claims); this is the change in the Member-weighted Benefit Relativity Factors for Claims (from Attachment 3) between the Experience Period and the Rating Period.

(14) Change in Seasonality Factor; this is the change in the Member-weighted Seasonality Factors for Claims (from Attachment 10) between the Experience Period and the Rating Period.

(15) Benefit changes: ACA and "Other"; these are the composite benefit change values attributable to both the mandated ACA benefits and the Anthem proposed "Other" benefit revisions (Attachments 11 and 12, respectively).

(16) Cumulative Trend; this is the total Medical Trend between the Experience Period and the Rating Period [i.e. the annualized Medical Trend from Step (9) and the Months of Trend from Step (11)].

(17) Rating Period Claims PMPM; this is calculated by applying the various claim projection factors in Steps (12) through (15) and the Cumulative Trend factor in Step (16) to the Adjusted Claims PMPM in Step (6).

(18) Change in Premium Duration Factor; this is the change in the Member-weighted Premium Duration Factor (from Attachment 7) between the Experience Period and the Rating Period.

(19) Change in Plan Mix (Premium) Factor; this is the change in the Member-weighted Benefit Relativity Factors for Premiums from Attachment 3.

(20) Adjusted Premium at Current Rates PMPM; this is calculated by applying the premium adjustment factors in Steps (18)and (19) to the Premium at Current Rates in Step (8).

(21) Target Loss Ratio; this is Anthem's Target Loss Ratio that is essentially established to meet internal financial targets while ensuring compliance with the California Code.

(22) Required Premium PMPM; the Required PMPM is the premium PMPM required to achieve the Target Loss Ratio. The Required Premium PMPM is calculated by dividing the Rating Period Claims PMPM from Step (17) by the Target Loss Ratio in Step (21).

(23) Required Rate Increase; this is calculated by dividing the Required Premium PMPM in Step (22)by the Adjusted Premium at Current Rates in Step (20).

(24) Proposed Rate Change (with benefit changes); virtually all pricing decisions ultimately come down to balancing a series of complex internal and external variables and considerations, including but not limited to the need to maintain sound financial discipline, competitive considerations, and regulatory pressures. . The culmination of these considerations is captured in this Step.

(25) Proposed Rate Change (without benefit changes); this Step is analogous to Step (24) but adjusts the Proposed Rate Change to reflect what the rate changes would be in the absence of both ACA mandated benefits and the Anthem proposed benefit changes.

(26) Expected CY 2011 Loss Ratio; this Step is populated from the monthly projections in the LLR Model.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the Rate Development Process and believe they are actuarially sound and the assumptions reasonable.

H. **Preparing and Analyzing the LLR Model** – the final analytical step to the Rate Development Process involves populating the LLR Model with the various aforementioned data, assumptions, and calculations. This is an iterative process that involves coordinating and integrating the ultimate results from the LLR Model with the ultimate results described in Section IV.G. above for the Rate Development Process.

A separate LLR Model is prepared for each Policy Form impacted by the Rate Filing. The primary objective of this exercise is to ensure compliance with the California Code.

The steps involved include:

(1) Develop initial "Starting Points" for normalized Premium PMPMs and Claims PMPMs. The Premium and Claims PMPM are normalized for the various factors described in Section IV.G. for the Rate Development Process (e.g. Premium and Claims Durational Factors, Plan Mix Factors, and Seasonality).

The Starting Point Claims must also be trended to the Starting Point (i.e. July 2010 for the Rate Filing) and Premiums must be adjusted to the Current Rate Basis.

(2) The LLR Model must be populated with month-by-month historical membership, which are projected by applying lapse rates to existing members and, when applicable, new sales assumptions. Since all of the Policy Forms in the Rate Filing are closed blocks, new sales assumptions were not required. The lapse assumptions are shown in Attachment 4.

(3) The LLR Model projects month-by-month membership, premium, and claim information using all of the data, assumptions, and calculations discussed throughout this Report.

(4) The LLR Model projects claims for 15 years and, accordingly, requires Medical Trend and Rate Change assumptions for this entire duration. Attachments 15 and 16 show the Leveraged Medical Trend and Rate Change assumptions, respectively used by the LLR Model. The Leveraged Medical Trend assumptions grade down from 2010 levels to constant levels for each Policy Form for projection years 2016 through 2025. The reduced constant Leveraged Medical Trend assumptions are about 38% below 2010 levels.

This gradual reduction in Leveraged Medical Trends reflects Anthem's assumption that Leveraged Medical Trends will eventually equate to the true Underlying Leveraged Medical Trends, exclusive of Adverse Selection. ActMod believes that this is an optimistic view of future events but we also believe that this assumption is consistent with industry norms for future projections. More important to the LLR Model projections than the absolute level of Leveraged Medical Trend assumptions is the relationship between the Leveraged Medical Trend assumptions and the corresponding rate change assumptions, which are discussed in the below paragraph. ActMod believes this assumed relationship to be reasonable and appropriate.

Rate change assumptions also grade down to constant levels for each Policy Form for projection years 2016 through 2025. The assumed rate changes are identical to the Leveraged Medical Trend assumptions from 2012 through the end of the projection period. The only exception is for the Basic Hospital Plans Policy Form for which the assumed rate changes are identical to the Leveraged Medical Trend assumptions from 2013 through the end of the projection period. The assumed 2012 rate change for the Basic Hospital Plans Policy Form, however, reflects its recent favorable experience and is assumed to equal a below trend percentage of 5.0%.

(5) In addition to the Leveraged Medical Trend assumption for the Tonik Policy Form, Anthem assumes an 8.0% trend for the entire projection period for the Dental and Vision benefits that are included in only the Tonik Policy Form.

(6) Since the end product of the LLR Model involves present value calculations for Premiums and Claims, a discount rate must be assumed. Anthem continues to use a discount rate of 4.31%, which was the 30 year U.S. Treasury Bond rate in September 2009. This same rate was used for prior filings with the CDI that was reviewed by AHP and found to be reasonable.

(7) The Calendar Year by Calendar Year MLR's and the Future and Lifetime LLRs by Policy Form that are developed by the LLR Model are shown in Attachment 17. The Future and Lifetime Medical Loss Ratios are also displayed in a Table in Section V below. The ratios shown demonstrate compliance with the California Code.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the LLR Model and believe they are actuarially sound and the assumptions reasonable.

V. SUMMARY OBSERVATIONS AND OPINIONS

The California Code requires that the Future MLR and the Lifetime MLR must each be not less than 70%. The compliance with ACA-defined MLRs is discussed in Section VI.

The below table summarizes Anthem's projected Future MLR for each Policy Form. As illustrated in the Summary Table, the Future MLR for each Policy Form meets or exceeds the California Code's 70% requirement. Consequently, the expected Future and Lifetime MLRs produced by the Rate Filing, in our opinion, comply with the California Code.

Summary Table of Policy Form Groupings

Abbreviated Name for Policy Form Group	Sep-2010 Members	Lifetime Loss Ratio	Future Lifetime Loss Ratio
SmartSense	211,590	79.3%	84.2%
Basic Hospital Plans	91,670	70.8%	88.7%
PPO Share (CDI)	76,179	80.5%	88.6%
3500 Deductible Plans	87,661	77.5%	84.1%
Right Plan	50,825	80.9%	89.0%
Tonik	37,847	77.5%	86.2%
Lumenos w/o Maternity	29,406	76.9%	80.8%
PPO Saver	13,369	78.6%	89.7%
Lumenos w/ Maternity	10,611	165.1%	180.9%
ClearProtection	19,966	73.5%	79.5%
CoreGuard	5,368	74.2%	80.8%
Premier	4,190	80.2%	84.7%
Total	**638,681**	**78.9%**	**87.4%**

The Table below (the "Rate Change Table") shows the average rate changes Anthem has proposed for each Policy Form:

Abbreviated Name for Policy Form Group	Average Rate Change[(1)]			
	Before Benefit Changes	ACA Benefit Change Impact	Other Benefit Change Impact	Net Rate Change
SmartSense	15.3%	2.3%	(4.5%)	12.7%
Basic Hospital Plans	(9.6%)	0.5%	0.0%	(9.2%)
PPO Share (CDI)	20.8%	0.3%	(5.7%)	14.2%
3500 Deductible Plans	21.9%	0.9%	(8.3%)	12.7%
Right Plan	17.3%	0.4%	(3.0%)	14.2%
Tonik	14.4%	0.7%	(4.3%)	10.3%
Lumenos w/o Maternity	16.6%	0.6%	(8.1%)	7.8%
PPO Saver	12.7%	0.6%	0.0%	13.4%
Lumenos w/ Maternity	23.5%	0.5%	(8.0%)	14.1%
ClearProtection	(0.6%)	8.5%	0.0%	7.8%
CoreGuard	(1.0%)	4.3%	0.0%	3.3%
Premier	6.4%	7.3%	0.0%	14.2%
Total	**13.4%**	**1.3%**	**(4.4%)**	**9.8%**

(1) Average Rate Changes for Grandfathered & Non-Grandfathered Policies Combined

It is important to recognize how the above proposed rate increases interact with existing rates and already approved rate changes. Specifically, the following two items impact a Member's rate change:

1. Member Aging - The rate tables used by Anthem vary with the actual Member's age. Thus, even without the rate changes proposed in the Rate Filing, Members would receive rate increases on their Policy Anniversary due to their, in general, being one year older than their prior Policy Anniversary. The Rate Change Table reflects increases above the rates already in place (i.e. the Rate Change Table excludes the impact of aging).

2. Anniversary Months and Rate Guarantees - Certain Members have not yet received the rate changes implemented in October 2010 due to the distribution across Policy Anniversary months and/or rate guarantees. When these Members reach their Policy Anniversary, in the absence of Anthem designed rate limits (i.e. "Rate Caps"), their rates would have to reflect prior and current rate changes to maintain equity with other Members.

The above two rate change impacts notwithstanding, Anthem has traditionally included Rate Caps in its Rate Filings. That is, the total rate change for a Member, inclusive of Aging and rate changes not received for prior rate change periods is limited to a certain percentage; for this Rate Filing that percentage is 24.9% (22.5% excluding the impact of Aging). The impact of rating characteristics other than Aging (i.e. geographic area and family contract type) are not considered in the application of the Rate Cap.

ActMod's analysis concluded that for the above twelve Policy Forms, the rates developed comply with the California Code, are reasonable, and are actuarially sound.

VI. COMPLIANCE WITH SB 1163 DRAFT GUIDANCE

The specific requirements of the SB 1163 Draft Guidance are included below in Bold Type in whole or in summary form for the reader's convenience and for reference purposes. The complete copy of the SB 1163 Draft Guidance is included as Attachment 22. ActMod's response regarding compliance is noted immediately below each provision:

Section A: Unreasonable Rate Increases:

1) The relationship of the projected medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law.

Attachment 18A is an ActMod summarization of more detailed Exhibits prepared by Anthem that demonstrates compliance for Calendar Year 2011 with the ACA-defined minimum loss ratio standard of 80% for Individual Health Insurance Policies.

The detailed analysis that ActMod discusses in Sections III and IV of this Report address the Policy Forms impacted by the Rate Filing. ActMod also reviewed the basic assumptions that Anthem used to prepare the projections for its other individual health care product offerings. These projections are included as Attachments 18A through 18C.

Attachments 18B and 18C are projections showing month by month results for Calendar Year 2010 and Calendar Year 2011 by major product line and in the aggregate for Anthem's individual health care business.

Attachment 18A is a summary exhibit for 2011 for all of Anthem's individual health care products that shows a projected ACA-defined MLR of 81.4%.

Attachment 18A also shows the ACA-defined adjustments to the MLR calculation that ActMod accepted from Anthem as accurate without audit or verification. Specifically:

1. Medical Management Expenses that are calculated as a percentage of premium but added to Claims in the calculation of the ACA-defined MLR.
2. Premium Tax, Federal Income Tax, and Payroll Tax that are calculated as a percentage of premium but subtracted from Premium in the calculation of the ACA-defined MLR.

In the opinion of both ActMod and James P. Galasso, the information summarized in Attachment 18A is a reasonable projection of Calendar Year 2011 results for Anthem's individual health care business and the resulting ACA-defined MLR of 81.4% demonstrates compliance with the projected medical loss ratio standard promulgated by ACA.

2) Whether the assumptions on which the rate increase is based are supported by substantial evidence.

As noted throughout this Report, it is the opinion of both ActMod and James P. Galasso that Anthem's Rate Filing assumptions are reasonable and supported by substantial and documented evidence. ActMod notes that "substantial" is a subjective non-actuarial term. But for the purposes of this Rate Filing review, ActMod defines substantial as the methodologies and applications of the methodologies as sufficient to reach the actuarial judgments presented throughout this report – including our opinion of the reasonableness of the proposed rate changes. In addition to the methodologies themselves, we also include in the definition of substantial our belief that the data relied upon for the application of the methodologies was credible and adequate for the task.

3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is reasonable.

As noted throughout this Report, it is the opinion of both ActMod and James P. Galasso that Anthem's methodology and choice of Rate Filing assumptions are reasonable. ActMod notes that while "reasonable" is a subjective term, actuaries often apply "actuarial judgment" to develop opinions regarding the reasonableness of benefits in relation to premiums charged for rate filings. For the purpose of this Rate Filing, ActMod defines reasonable as having sufficient, credible, and relevant data such that an experienced actuary could review the available information and make an informed judgment by applying actuarial standards to determine the reasonableness of each relevant assumption used in the preparation of the Rate Filing.

4) Whether the data or documentation provided to the Department in connection with the filed rate increase is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of the rate may be determined.

It is ActMod's belief that the information that Anthem has provided the CDI for the Rate filing is adequate, complete, and a reasonable basis for the CDI's review of the Rate Filing. It is our understanding that in addition to the 24 page Actuarial Memorandum in support of the Rate Filing, Anthem also provided detailed responses and Exhibits to CDI follow-up questions. Additionally, and as noted in this Report, many of the key methodologies and assumptions in support of the Rate Filing have been previously reviewed and found to be reasonable and adequate by the CDI and its external actuarial consultant AHP.

Accordingly, it is the opinion of both ActMod and James P. Galasso that the data or documentation provided to the CDI in connection with the filed rate increases is sufficient and adequate for the CDI to determine the reasonableness of the requested rate changes.

5) Whether the filed rates result in premium differences between insureds within similar risk categories that:

a) Are otherwise not permissible under applicable California law; or

In the opinion of both ActMod and James P. Galasso, the Rate Filing has no rates or rating classifications between insureds that are not permissible under applicable California law.

b) Do not reasonably correspond to differences in expected costs.

Certain aspects regarding cost differentials, such as geographic area factors and underwriting tier factors, were not reviewed by ActMod for other than reasonableness. We did ask Anthem to provide us with test analysis to demonstrate that, in the aggregate, such factors were consistent with and did not distort the premiums or rate changes in the Rate Filing. For example, please refer to Attachment 9.

In other respects and consistent with Actuarial Standards of Practice, we relied on the qualified actuary identified in Attachment 2. Such reliance is typical and, we believe, universal when an external and independent actuary is asked to assist a company with complex actuarial issues – especially actuarial issues requiring the detailed review of a company's own data.

Based on the above, it is the opinion of both ActMod and James P. Galasso that the premiums and rate changes in the Rate Filing do reasonably correspond to differences in expected costs.

6) Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible experience data.

We reviewed the itemized changes (e.g. membership, benefit plan, premium, and claims information) in great detail and believe they are all justified by credible experience. As noted in the report, when credible experience data was not directly available (i.e. the experience data for the less than fully credible CoreGuard and Premier Policy Forms), we believe that Anthem used appropriate credible substitute data and made the appropriate adjustments to that data.

Accordingly, it is the opinion of both ActMod and James P. Galasso that the requested rate changes are substantially justified by credible experience data.

7) The company's rate of return, evaluated on a return-on-equity basis, for the prior three years, and anticipated rate of return for the following year, taking into account investment income.

In response to this request, Anthem provided ActMod what is included in this Report as Attachment 19. This is not something that ActMod, nor do we believe other external actuarial consultants, would typically review in the context of a single Rate Filing. The information is attached per the SB 1163 Draft Guidance but we do not believe it is relevant to the review and opinions expressed in this Report.

Therefore neither ActMod nor James P. Galasso identified anything in the Rate Filing that would cause us to consider the Rate Filing to be unreasonable due to the company's rate of return.

8) The insurer's employee and executive compensation.

In response to this request, Anthem provided ActMod what is included in this Report as Attachments 20A and 20B. These Attachments consist of blank exhibits that show the compensation information included each year in Anthem's Statutory Statements annual filings. Of course, actual compensation information would accompany the Statutory Statement filings.

ActMod did not consider nor do we understand how an actuary would consider this type of information in determining the reasonableness of a rate filing. Therefore neither ActMod nor James P. Galasso identified anything in the Rate Filing that would cause us to consider the Rate Filing to be unreasonable due to employee and executive compensation.

9) The degree to which the increase exceeds the rate of medical cost inflation as reported by the U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index.

In response to this request, Anthem provided ActMod with the Table shown in Attachment 21. The preparer of this Report, James P. Galasso, has over 30 years' experience involving health care pricing and related actuarial issues. During this time it has always been evident to Mr. Galasso and, we believe, the actuarial community in general that the Medical Care component of the Consumer Price Index materially understates medical trend in general and the medical cost drivers of health care premiums in particular.

Accordingly, ActMod added the "boxed" area to the right of the table in Attachment 21. The text in the boxed area is an excerpt from the Bureau of Labor Statistics website that explains some of the components of the Medical Care CPI. ActMod highlighted the last sentence that we believe is particularly relevant. Specifically, it notes that the Medical Care component of the CPI "only includes consumers' out-of-pocket expenditures (and excludes employer provided health care). . ." The Medical Care component of the CPI also excludes government expenditures (e.g. Medicare and Medicaid payments) from the Medical Care component of the CPI.

With government alone accounting for approximately 50% of total health care spending in the United States and employers paying the preponderance of the remaining 50%, we seriously question the use of the Medical Care component of the CPI as an indicator against which rate increases for health insurance premiums should be compared.

We make the observation in support of our belief that the Medical Care component of the CPI is an arbitrary, artificial, and erroneous indicator with respect to the drivers of health insurance premiums. We would also note and as described elsewhere in this Report that the Medical Trends for individual health insurance are subject to forces well in excess of what is considered "Underlying Medical Trend" (e.g. Adverse Selection, Underwriting Wear-Off, and Medical Trend Leverage).

Nevertheless and in compliance with the SB 1163 Draft Guidance, we provide the following information:

As noted in Attachment 21, the Medical Care component of the CPI for 2010 is shown as 3.4%. The 2010 Leveraged Medical Trends used in the Rate Filing range from a low of 15.4% for the Right Plan to a high of 19.4% for CoreGuard. As previously noted in this Report, the Medical Trend differences by Policy Form are solely attributable to Medical Trend Leverage. We also note Anthem's estimate, which ActMod concurs is reasonable, that the Leveraged Medical Trends used in the Rate Filing include about 8 percentage points of Adverse Selection that, as noted above, is completely ignored by the Medical Care component of the CPI.

In the opinion of both ActMod and James P. Galasso, it is not unusual or unreasonable for rate changes for individual health care plans to exceed the Medical Care component of the CPI to the same extent as that noted above for the Rate Filing. Accordingly, it is also our opinion that the differential between the Medical Care component of the CPI and the Rate Filing proposed rate changes should **not** cause the Rate Filing to be deemed "unreasonable".

10) For individual policies, whether the proposed rates comply with California Code of Regulations Title 10, section 2222.12 (the "California Code"). ***ActMod note: The California Code defines and requires that the Lifetime Anticipated Loss Ratio (the "Lifetime MLR") and "the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage" (the "Future MLR") must each be not less than 70.0%. The recent revision to the California Code also requires that proposed rates comply with ACA-defined minimum MLR requriements.***

As stated in Section V of this Report and as demonstrated in the Summary Table of Policy Form Groupings in that same Section, in the opinion of both ActMod and James P. Galasso the Rate Filing complies with the 70% Lifetime minimum MLR requirements of the California Code.

As also discussed in the above Section A item (1) that addresses compliance with the SB 1163 Draft Guidance, it is the opinion of both ActMod and James P. Galasso that the Rate Filing complies with the ACA-defined minimum MLR requirements.

Section C: Actuarial Certification

14) (A) The Actuarial Certification is considered:

(1) A "Statement of Actuarial Opinion"

Both ActMod and James P. Galasso understand that this Report is deemed to be a Statement of Actuarial Opinion and we have prepared the Report, to the best of our ability, to comply with our professional obligations in this regard.

(2) A "Health Filing", as defined in Actuarial Standard of Practice ("ASOP") No.8

Both ActMod and James P. Galasso understand that the Rate Filing subject to review by this Report is considered a Health Filing and, as such, is subject to the actuarial standards described in ASOP No. 8.

(3) An "Actuarial Communication", as defined by ASOP No. 41

Both ActMod and James P. Galasso understand that this Report is deemed to be an "Actuarial Communication" and we have prepared the Report, to the best of our ability, to comply with our professional obligations in this regard.

(B) The Actuarial Certification must include:

(1) A statement (i) describing the actuary's qualifications, (ii) that the actuary meets the Qualification Standards for *Actuaries Issuing Statements of Actuarial Opinion in the United States*, and (iii) that the actuary meets California's legal requirements for independence.

As stated in Section I of this Report, Mr. Galasso meets the Qualification Standards for *Actuaries Issuing Statements of Actuarial Opinion in the United States* to issue the opinions contained herein. Mr. Galasso also meets the independence requirements stated in the California Insurance Code section 10181.6 (b)(3).

(2) A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate. Premium rates are actuarially sound if, for business in California and for the period covered by the certification, the total of projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income is adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of required capital.

Both ActMod and James P. Galasso can affirmatively state that, in our opinion, the proposed premium rates are actuarially sound for the business in California and for the period covered by the certification (i.e. the Rating Period). We reviewed the projected premium income, any expected reinsurance cash flows (there were none), and any governmental risk adjustment cash flows (there were none).

As noted in Section I, the projection period assumed the proposed rates would be effective April 1, 2011. For actuarial soundness to be maintained, Rate filing delays beyond this assumed effective date require that Anthem implement their proposed rate deferral factor of 1.3% for each month of delay for each Policy Form.

We did not review, however, investment income as regards the Policy Forms impacted by the Rate Filing. In our opinion, investment income for short term medical care policies is typically not explicitly considered during the rate development process. The reason is that, unlike for longer term product offerings such as disability income policies or long term care insurance, investment income is not a significant part of the income stream for short term medical care policies.

With respect to expected costs, we reviewed the expected cost of health benefits (i.e. claims expenses), but we did not review underlying administrative expenses such as marketing and administrative expenses nor did we review the cost of required capital. The reason that we did not conduct such a detailed review is because Anthem prepared the Rate Filing and the Rate Development Process using what is typically known as the "Loss Ratio" approach.

The Loss Ratio approach merely requires the establishment of Target Medical Loss Ratios that are in compliance with all relevant laws and regulations and are deemed satisfactory to the

company. In this case, Anthem has assured ActMod that it is comfortable with the chosen Target Medical Loss Ratios and ActMod verified, to the best of its ability, that the ultimate proposed Medical Loss Ratios complied with all appropriate laws and regulations.

With the above understanding, again, ActMod and James P. Galasso can both affirmatively state that, in our opinion, the proposed premium rates are actuarially sound for the business in California and for the period covered by the certification (i.e. the Rating Period).

(3) For each contract or insurance policy included in the filing, a complete description of the data, assumptions, rating factors, and methods used to determine the premium rates, with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract or policy form included in the filing.

We hope that the time and effort expended by ActMod and James P. Galasso in the preparation of this Report is evident to the reader. We believe that we have covered the Rate Development process and a description of the data, assumptions, factors, and methods that would enable a qualified health actuary to make an objective appraisal of our opinions and the reasonableness of the premiums and rate changes proposed in the Rate Filing.

Given the acknowledged complexity of the Rate Filing preparation process, we are also agreeable to responding to any questions or concerns that may require clarification.

We trust that Attachments 14A and 14B (the Rate Development Process) and the corresponding detailed explanations in Section IV. G. satisfies the requirement that "descriptions must include examples of rate calculations for each contract or policy form included in the filing".

(4) A statement of opinion, with respect to each individual or small group rate increase included in the filing, whether the rate increase filed is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies, including benefit relativities that reflect the expected variations in cost, taking into consideration historical experience and the credibility of the historical data. Statements of opinion regarding whether a rate increase is reasonable or unreasonable shall discuss the factors listed in Section A, "Unreasonable Rate Increases," of this Guidance. In addition, statements of opinion regarding individual health insurance shall discuss whether the benefits provided under the policy are reasonable in relation to the premium charged, as described in the California Code.

Based on the information discussed in Section A above, it is the opinion of both ActMod and James P. Galasso that each of the rate increases in the Rate Filing is reasonable.

(5) A description of the testing performed by the actuary to arrive at the statements of opinion in paragraphs (B)(2) and (B)(4) above, including any independent rating models and rating factors utilized.

Our review consisted almost entirely of a thorough review of the detailed information and data files provided to us by Anthem. Areas for which specific testing was requested or applied consisted of the following:

(i) Testing Potential Medical Trend Impact of Geographic Area and Underwriting Tier Distributions: As noted in the Report, we requested information from Anthem to test the reasonableness of the Medical Trend assumptions as regards Geographic Area Factors and Underwriting Tier Factors. The information we received is included as Attachment 9. The testing verified Anthem's assumption that the distribution of Members by Geographic Area and Underwriting Tiers had no material impact on Medical Trends.

(ii) Testing of Change in Claim Durational Factors on Future/Lifetime Loss Ratios and Medical Trends: As noted in this Report, ActMod conducted independent testing of the impact of the change in Claim Durational Factors from the prior rate filing. We concluded that the change resulted in lower Future and lower Lifetime Loss Ratios (see Attachment 6) thus making it more challenging for Anthem to comply with the California Code's minimum loss ratio requirements. Even with the more challenging assumptions, the Rate Filing complied with the California Code. Our testing of Medical Trends demonstrated that the change in the Claim Durational Factors had an immaterial impact on the ultimate Medical Trend assumptions.

ActMod thanks Anthem for the opportunity to prepare this Report and would be pleased to respond to any questions or supplement the Report as may be deemed necessary.

Respectfully submitted,

James P. Galasso, FSA, MAAA, CERA
President & Consulting Actuary
Actuarial Modeling

Attachments

Attachment 1A

Curriculum Vitae

James P. Galasso, FSA, MAAA, CERA
President & Consulting Actuary
Actuarial Modeling

333 Sandy Springs Circle
Suite 101
Atlanta, Georgia 30328

Email: jgalasso@actuarialmodeling.com
Office: (404) 531-0379

Jim Galasso is a Fellow in the Society of Actuaries, a Member of the American Academy of Actuaries, and a Chartered Enterprise Risk Analyst. He has over 30 years experience in health care, serving in the capacity of Chief Financial Officer, Chief Actuary, and as an Actuarial Consultant. Prior to incorporating and serving as the President & Actuarial Consultant for Actuarial Modeling, Mr. Galasso served as a Partner with Ernst & Young LLP, managing E&Y's Southeast actuarial healthcare practice.

Mr. Galasso has performed various actuarial services for numerous Commercial Insurance Carriers, Blue Cross Blue Shield Plans, Health Maintenance Organizations, Governmental Entities, Health Care Providers, and Large Employers. Such services include but are not limited to:

(1) Actuarial & Financial Due Diligence
(2) Actuarial Reserve Reviews (including IBNR and Premium Deficiency Reserves)
(3) Actuarial Valuations
(4) Group Health Employee Benefit Programs
(5) Pricing Medical Care Benefit Plans
(6) Reviewing Prescription Drug Programs [including Pharmacy Benefit Managers (PBM)]
(7) Risk-Based Capital Reviews
(8) Health plan organization realignments
(9) Predictive Risk Modeling / Health Risk Adjusters
(10) Underwriting policy and procedure reviews
(11) Rate filing preparations and testimony
(12) Provider contracting and network management
(13) Risk assessments for Provider Sponsored Organizations
(14) Merger and Acquisition engagements
(15) Medicare Supplement Products
(16) Medicare and Medicaid managed care programs
(17) Blue Cross and Blue Shield audits and actuarial consulting
(18) HMO and PSO audits and actuarial consulting
(19) Behavioral health audits and actuarial consulting
(20) Expert Witness Testimony
(21) Serving on Arbitration Panels

Professional Experience

Mr. Galasso has developed a comprehensive package of actuarial and financial reporting tools consisting of, but not limited to, the following:

(1) An "Incurred But Not Reported" (IBNR) estimation software model
(2) A medical cost & premium development software model for healthcare companies
(3) An aggregate and specific stop loss rating software model
(4) A MediGap pricing software model that accommodates both 1990 and 2010 standard plans
(5) A large group underwriting software model
(6) A physician fee evaluation software model
(7) A hospital reimbursement evaluation software model
(8) A prescription drug evaluation software model
(9) A financial projection software model for healthcare companies
(10) A market segment reporting and trend monitoring software model
(11) A capital management and risk-based capital analysis software model
(12) A process for monitoring, pricing, and underwriting groups and group rating parameters

Qualifications

Mr. Galasso maintains his standing as a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Chartered Enterprise Risk Analyst by pursuing continuing education credits, frequently speaking at various actuarial conferences, publishing actuarial papers, and developing / presenting to actuaries various actuarial training courses for continuing education credit. Papers written by Mr. Galasso and offered to the actuarial community include:

(1) Financial Reporting for Health Care Companies
(2) Incurred But Not Paid ("Reported") Claim Liabilities ("IBNR") – The Basics
(3) Risk-Based Capital - the Basics
(4) Block Underwriting for Health Care Companies

Seminars and Training

Mr. Galasso attends and/or speaks at various seminars and conferences sponsored by the Society of Actuaries, the Southeastern Actuaries Conference, and other industry conferences.

Education

Mr. Galasso graduated with honors from the State University of New York at Stony Brook with majors in both Theoretical and Applied Mathematics. His post graduate activities included studying for and successfully completing the series of examinations offered by the Society of Actuaries, culminating in Mr. Galasso's obtaining his Fellowship in the Society of Actuaries.

Actuarial Reliance Certification

I, Fritz Busch, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the American Academy of Actuaries continuing education standards and am qualified to have prepared and/or reviewed the actuarial analysis and data that I provided to Mr. James P. Galasso for his review and certification of the Rate Filing dated February 2, 2011 and prepared by the Anthem Blue Cross Life and Health Insurance Company.

Fritz Busch, FSA, MAAA
Regional Vice President Individual
WellPoint Inc.
February 23, 2011

BENEFIT PLAN RELATIVITIES

	Policy Form	Contract Description	Benefit Plan Relativity Factors Claims[1]	Premiums[2]
1.	3500	3500 Deductible PPO	0.92	0.85
2.	3500	HSA	0.90	0.69
3.	RIGHT_PLAN	Right Plan 40 - no Rx	1.00	0.99
4.	RIGHT_PLAN	Right Plan 40-R - Generic Rx	0.87	0.77
5.	RIGHT_PLAN	Right Plan 40 - Generic Rx	1.03	1.10
6.	RIGHT_PLAN	Right Plan 40-R - full Rx	0.91	0.87
7.	RIGHT_PLAN	Right Plan 40 - full Rx	1.15	1.28
8.	TONIK	Tonik 1500	1.12	1.31
9.	TONIK	Tonik 3000	1.02	0.93
10.	TONIK	Tonik 5000	0.94	0.70
11.	CDHP-noMat	Non-maternity CDHP HIA 1500	1.00	1.00
12.	CDHP-noMat	Non-maternity CDHP HIA 3000	0.89	0.79
13.	CDHP-noMat	Non-maternity CDHP HIA 5000	0.85	0.74
14.	SMART_SENSE	SmartSense 500 GenRX	1.04	1.16
15.	SMART_SENSE	SmartSense 1500 GenRX	0.91	0.82
16.	SMART_SENSE	SmartSense 2500 GenRX	0.83	0.70
17.	SMART_SENSE	SmartSense 5000 GenRX	0.78	0.63
18.	SMART_SENSE	SmartSense 500 FullRX	1.14	1.34
19.	SMART_SENSE	SmartSense 1500 FullRX	1.01	1.00
20.	SMART_SENSE	SmartSense 2500 FullRX	0.94	0.89
21.	SMART_SENSE	SmartSense 5000 FullRX	0.89	0.81
22.	PPO_SHARE	PPO Share 500	1.18	2.27
23.	PPO_SHARE	PPO Share 1000	1.12	2.15
24.	PPO_SHARE	PPO Share 5000	0.86	1.07
25.	PPO_SHARE	PPO Share 5000-R (CDI)	0.80	0.90
26.	SAVER	PPO Saver	1.02	1.00
27.	BASIC	Basic 1000	0.73	0.56
28.	BASIC	Basic 2500	0.64	0.50
29.	BASIC	CORE 5000	0.59	0.49
30.	CDHP-Mat	Maternity CDHP HIA 1500	1.18	1.95
31.	CDHP-Mat	Maternity CDHP HIA 2500	1.06	1.62
32.	CDHP-Mat	Maternity CDHP HIA 3000	1.01	1.46
33.	CDHP-Mat	Maternity CDHP HIA 5000	0.84	0.93
34.	CLEAR_PROTECTION	ClearProtection 1000	0.87	0.76
35.	CLEAR_PROTECTION	ClearProtection 3300	0.76	0.61
36.	CLEAR_PROTECTION	ClearProtection 5000	0.70	0.49
37.	CORE_GUARD	CoreGuard 750	0.98	1.09
38.	CORE_GUARD	CoreGuard 1500	0.91	0.74
39.	CORE_GUARD	CoreGuard 2500	0.84	0.64
40.	CORE_GUARD	CoreGuard 3500	0.82	0.62
41.	CORE_GUARD	CoreGuard 5000	0.77	0.57
42.	CORE_GUARD	CoreGuard 7500	0.73	0.51
43.	CORE_GUARD	CoreGuard 10000	0.70	0.49
44.	PREMIER	Premier 1000	1.25	1.69
45.	PREMIER	Premier 1500	1.15	1.34
46.	PREMIER	Premier 2500	1.11	1.17
47.	PREMIER	Premier 3500	1.05	1.10
48.	PREMIER	Premier 5000	0.98	1.04
49.	PREMIER	Premier 6000	0.95	0.96

(1) Claims factors are based on benefit relativity with maternity claims removed.

(2) Premiums factors are normalized for age, sex, area, contract type, and und tier.

Monthly Lapse Rates			
Duration	BASIC	Standard PPO	High Ded PPO
1	0.14%	0.28%	0.09%
2	4.54%	5.79%	3.57%
3	4.54%	5.14%	3.51%
4	4.54%	5.07%	3.44%
5	4.32%	4.41%	3.31%
6	4.32%	4.41%	3.31%
7	3.96%	4.39%	3.31%
8	3.96%	4.39%	3.29%
9	3.66%	4.39%	3.29%
10	3.66%	4.39%	3.29%
11	3.63%	4.39%	3.29%
12	3.63%	4.35%	3.07%
13	3.48%	4.35%	3.07%
14	3.48%	4.35%	3.07%
15	3.33%	4.35%	2.97%
16	3.33%	4.32%	2.97%
17	3.03%	4.32%	2.97%
18	3.03%	4.32%	2.80%
19	3.03%	4.32%	2.80%
20	2.80%	4.05%	2.80%
21	2.80%	4.05%	2.59%
22	2.80%	4.05%	2.59%
23	2.71%	4.05%	2.59%
24	2.71%	3.91%	2.59%
25	2.71%	3.91%	2.47%
26	2.58%	3.91%	2.47%
27	2.58%	3.91%	2.47%
28	2.58%	3.76%	2.47%
29	2.42%	3.76%	2.31%
30	2.42%	3.76%	2.31%
31	2.42%	3.76%	2.31%
32	2.42%	3.40%	2.31%
33	2.42%	3.40%	2.31%
34	2.35%	3.40%	2.31%
35	2.35%	3.40%	2.31%
36	2.35%	3.40%	2.31%
37	2.35%	3.40%	2.31%
38	2.35%	3.40%	2.31%
39	2.25%	3.40%	2.31%
40	2.25%	3.40%	2.31%
41	2.25%	3.40%	2.31%
42	2.25%	3.40%	2.31%
43	2.25%	3.40%	2.31%
44	2.14%	3.40%	2.31%
45	2.14%	3.40%	2.31%
46	2.14%	3.40%	2.31%
47	2.14%	3.40%	2.31%
48	2.14%	3.40%	2.31%
49	2.11%	3.40%	2.31%
50	2.09%	3.40%	2.31%
51	2.09%	3.40%	2.31%
52	2.09%	3.40%	2.31%
53	2.09%	3.40%	2.31%
54	2.09%	3.40%	2.31%
55	2.01%	3.40%	2.31%
56	2.01%	3.40%	2.31%
57	2.01%	3.40%	2.31%
58	2.01%	3.40%	2.31%
59	2.01%	3.40%	2.31%
60 +	1.80%	3.40%	2.31%

NOTE	
BASIC =	Basic Hospital Plans
Standard PPO =	SmartSense, PPO Share, Right Plan, Tonik, Lumenos w/ Maternity, PPO Saver, ClearProtection, CoreGuard, and Premier
High Ded PPO =	3500 Deductible and Lumenos w/o Maternity

Claim Durational Factors

	Smart Sense	Basic	PPO Share	3500 Ded	Right Plan	Tonik[1]	Lumenos w/o Mat	PPO Saver	Lumenos w/ Mat	Clear Protection	Core Guard	Premier
quarter 1	0.675	0.712	0.604	0.471	0.675	0.675	0.471	0.675	0.604	0.675	0.675	0.675
quarter 2	0.826	0.926	0.727	0.609	0.826	0.826	0.609	0.826	0.727	0.826	0.826	0.826
quarter 3	0.973	0.930	0.909	0.822	0.973	0.973	0.822	0.973	0.909	0.973	0.973	0.973
quarter 4	0.992	1.009	0.925	0.919	0.992	0.992	0.919	0.992	0.925	0.992	0.992	0.992
year 2 *	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
year 3	1.089	1.289	1.171	1.145	1.089	1.089	1.145	1.089	1.171	1.089	1.089	1.089
year 4	1.186	1.321	1.244	1.203	1.186	1.186	1.203	1.186	1.244	1.186	1.186	1.186
year 5	1.356	1.683	1.478	1.328	1.356	1.356	1.328	1.356	1.478	1.356	1.356	1.356
year 6	1.608	1.747	1.539	1.523	1.608	1.608	1.523	1.608	1.539	1.608	1.608	1.608
year 7	1.810	1.775	1.549	1.668	1.810	1.810	1.668	1.810	1.549	1.810	1.810	1.810
year 8	1.847	1.810	1.580	1.701	1.847	1.847	1.701	1.847	1.580	1.847	1.847	1.847
year 9	1.884	1.846	1.612	1.735	1.884	1.884	1.735	1.884	1.612	1.884	1.884	1.884
year 10	1.921	1.883	1.644	1.770	1.921	1.921	1.770	1.921	1.644	1.921	1.921	1.921
year 11+	1.981	1.929	1.682	1.824	1.981	1.981	1.824	1.981	1.682	1.981	1.981	1.981

[1] Excluding Dental and Vision Benefits

Change in Claim Durational Factors
for 3500 Policy Form

	Prior	As Filed
quarter 1	0.575	0.471
quarter 2	0.678	0.609
quarter 3	0.823	0.822
quarter 4	0.863	0.919
year 2 *	1.000	1.000
year 3	1.300	1.145
year 4	1.416	1.203
year 5	1.620	1.328
year 6	1.920	1.523
year 7	2.162	1.668
year 8	2.205	1.701
year 9	2.249	1.735
year 10	2.294	1.770
year 11+	2.365	1.824

Impact of Updated Claim Durational Factors
on 3500 Policy Form Lifetime Loss Ratios

	Prior Factors	As Filed Factors
Future Lifetime Loss Ratio	95.4%	84.1%
Lifetime Loss Ratio	84.7%	77.5%

Premium Durational Factors

	Smart Sense	Basic	PPO Share	3500 Ded	Right Plan	Tonik(1)	Lumenos w/o Mat	PPO Saver	Lumenos w/ Mat	Clear Protection	Core Guard	Premier
quarter 1	0.945	0.949	0.901	0.912	0.945	0.945	0.912	0.945	0.901	0.945	0.945	0.945
quarter 2	0.946	0.951	0.904	0.927	0.946	0.946	0.927	0.946	0.904	0.946	0.946	0.946
quarter 3	0.971	0.952	0.913	0.936	0.971	0.971	0.936	0.971	0.913	0.971	0.971	0.971
quarter 4	0.981	0.965	0.929	0.951	0.981	0.981	0.951	0.981	0.929	0.981	0.981	0.981
year 2 *	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
year 3	1.069	1.043	1.103	1.079	1.069	1.069	1.079	1.069	1.103	1.069	1.069	1.069
year 4	1.123	1.088	1.224	1.133	1.123	1.123	1.133	1.123	1.224	1.123	1.123	1.123
year 5	1.202	1.170	1.330	1.213	1.202	1.202	1.213	1.202	1.330	1.202	1.202	1.202
year 6	1.301	1.248	1.385	1.313	1.301	1.301	1.313	1.301	1.385	1.301	1.301	1.301
year 7	1.403	1.314	1.403	1.416	1.403	1.403	1.416	1.403	1.403	1.403	1.403	1.403
year 8	1.490	1.286	1.431	1.504	1.490	1.490	1.504	1.490	1.431	1.490	1.490	1.490
year 9	1.520	1.312	1.459	1.534	1.520	1.520	1.534	1.520	1.459	1.520	1.520	1.520
year 10	1.550	1.338	1.488	1.564	1.550	1.550	1.564	1.550	1.488	1.550	1.550	1.550
year 11+	1.598	1.370	1.522	1.613	1.598	1.598	1.613	1.598	1.522	1.598	1.598	1.598

(1) Excluding Dental and Vision Benefits

Medical Trend Analysis and Assumptions

Product	Measured Medical Trend w/ Leverage[1] (1)	Product Leverage Factor (2)	Product Medical Trend w/o Leverage (3) = (1)/(2)	Composite Medical Trend w/ Product Leverage (4) = (2) x $(3)_{Total}$	Anthem Assumed Composite w/ Leverage[3] (5) = (4) x $[(5)/(4)]_{Totals}$
SmartSense	22.5%	1.15	19.5%	19.2%	16.5%
Right Plan	23.1%	1.08	21.4%	17.9%	15.4%
Tonik	7.4%	1.19	6.2%	19.7%	16.9%
Lumenos w/ Maternity	24.2%	1.24	19.5%	20.6%	17.6%
Lumenos w/o Maternity	9.2%	1.24	7.4%	20.6%	17.6%
3500 Deductible Plans	16.9%	1.26	13.4%	20.9%	17.9%
PPO Share (CDI)	32.6%	1.28	25.5%	21.2%	18.2%
PPO Saver	21.8%	1.13	19.3%	18.8%	16.1%
Basic Hospital Plans	(7.0%)	1.15	(6.1%)	19.1%	16.3%
Total[2]	**19.8%**	**1.19**	**16.6%**	**19.8%**	**17.0%**
Products without Credible Historical Experience					
ClearProtection		1.24	16.6%	20.7%	17.7%
CoreGuard		1.36	16.6%	22.6%	19.4%
Premier		1.22	16.6%	20.3%	17.4%

[1] Measured for 12-month period ending 6/30/2010 (claim payments through 9/30/2010)

[2] Composited with claims costs for 12-month period ending June 30, 2010

[3] Anthem assumed Medical Trends about 14% less than measured composite trends (i.e. assumed 17.0% Total Medical Trend versus measured trend of 19.8%; 17.0/19.8 - 1.0 = 14%)

VERIFICATION OF STABILITY OF AREA AND UNDERWRITING TIER FACTORS

	Average Rolling 12-month Rating Factors			
	Geographic Area		Underwriting Tier	
Month	Factor	Change		
Dec-07	1.005		1.038	
Jan-08	1.004		1.038	
Feb-08	1.004		1.038	
Mar-08	1.004		1.038	
Apr-08	1.004		1.038	
May-08	1.004		1.039	
Jun-08	1.004		1.039	
Jul-08	1.004		1.039	
Aug-08	1.004		1.039	
Sep-08	1.004		1.039	
Oct-08	1.004		1.040	
Nov-08	1.004		1.040	
Dec-08	1.003	(0.1%)	1.040	0.2%
Jan-09	1.003	(0.1%)	1.040	0.2%
Feb-09	1.003	(0.1%)	1.041	0.3%
Mar-09	1.003	(0.1%)	1.041	0.3%
Apr-09	1.003	(0.1%)	1.041	0.3%
May-09	1.003	(0.1%)	1.041	0.3%
Jun-09	1.003	(0.2%)	1.041	0.2%
Jul-09	1.002	(0.2%)	1.041	0.2%
Aug-09	1.002	(0.2%)	1.041	0.2%
Sep-09	1.002	(0.2%)	1.042	0.2%
Oct-09	1.002	(0.2%)	1.042	0.2%
Nov-09	1.001	(0.2%)	1.042	0.2%
Dec-09	1.001	(0.3%)	1.042	0.1%
Jan-10	1.001	(0.3%)	1.042	0.1%
Feb-10	1.000	(0.3%)	1.042	0.1%
Mar-10	1.000	(0.3%)	1.042	0.1%
Apr-10	N/A	N/A	1.042	0.1%
May-10	N/A	N/A	1.042	0.1%

SEASONALITY FACTORS[1]

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
SmartSense	0.915	0.820	0.971	0.934	0.959	1.012	1.069	0.981	1.007	1.126	1.067	1.138
Right Plan	0.962	0.854	1.002	0.955	0.973	1.017	1.065	0.969	0.987	1.095	1.030	1.090
Tonik	0.904	0.813	0.964	0.929	0.956	1.011	1.070	0.984	1.011	1.133	1.076	1.149
Lumenos w/ Maternity	0.808	0.744	0.900	0.886	0.930	1.002	1.077	1.007	1.052	1.196	1.151	1.246
Lumenos w/o Maternity	0.790	0.730	0.888	0.878	0.925	1.000	1.079	1.012	1.060	1.208	1.166	1.265
3500 Deductible Plans	0.801	0.739	0.896	0.883	0.928	1.001	1.078	1.009	1.055	1.200	1.157	1.253
PPO Share (CDI)	0.883	0.797	0.950	0.919	0.950	1.009	1.072	0.989	1.020	1.147	1.093	1.171
PPO Saver	0.940	0.838	0.988	0.945	0.966	1.015	1.067	0.975	0.996	1.110	1.048	1.113
Basic Hospital Plans	0.915	0.820	0.971	0.934	0.959	1.012	1.069	0.981	1.007	1.126	1.067	1.138
ClearProtection	0.915	0.820	0.971	0.934	0.959	1.012	1.069	0.981	1.007	1.126	1.067	1.138
CoreGuard	0.915	0.820	0.971	0.934	0.959	1.012	1.069	0.981	1.007	1.126	1.067	1.138
Premier	0.915	0.820	0.971	0.934	0.959	1.012	1.069	0.981	1.007	1.126	1.067	1.138

[1] NOTE: The Seasonality Factors for Basic Hospital Plans, ClearProtection, CoreGuard, and Premier were all set equal to the SmartSense Seasonality Factors

PROPOSED RATE CHANGES FOR ACA MANDATED BENEFITS

	Proposed Rate Changes for NGF[1] Policies			NGF Prem as % of GF+NGF Prem[3]	Average Rate Change [NGF & GF[2] Combined]
	For Preventive @ 100%	For Children Guranteed Issue	Total Impact		
SmartSense	8.5%	1.8%	10.4%	22.5%	2.3%
Right Plan	3.7%	1.8%	5.6%	6.7%	0.4%
Tonik	5.8%	0.0%	5.8%	12.2%	0.7%
Lumenos w/ Maternity	1.2%	1.3%	2.6%	20.1%	0.5%
Lumenos w/o Maternity	1.2%	1.3%	2.6%	22.3%	0.6%
3500 Deductible Plans	8.9%	1.8%	10.9%	8.3%	0.9%
PPO Share (CDI)	5.4%	0.2%	5.6%	4.9%	0.3%
PPO Saver	9.4%	1.8%	11.4%	5.5%	0.6%
Basic Hospital Plans	9.4%	1.8%	11.4%	4.5%	0.5%
ClearProtection	8.5%	1.8%	10.4%	81.4%	8.5%
CoreGuard	8.5%	1.8%	10.4%	41.3%	4.3%
Premier	5.4%	1.8%	7.3%	100.0%	7.3%
Total[3]	**7.2%**	**1.6%**	**8.9%**	**14.7%**	**1.3%**

[1] NGF = Non-Grandfathered Policies (i.e. Policies written on or after passage of ACA on 3/23/2010)

[2] GF = Grandfathered Policies (i.e. Policies written prior to passage of ACA on 3/23/2010)

[3] Weighted by September 2010 Premium

PROPOSED RATE CHANGES FOR "OTHER" PROPOSED BENEFIT CHANGES

	A	B	C	D	E	**Total[(1)]**
SmartSense	(2.2%)	(0.5%)	(0.4%)	(1.2%)	(0.4%)	**(4.5%)**
Right Plan	n/a	(0.3%)	(0.3%)	(1.9%)	(0.6%)	**(3.0%)**
Tonik	(3.0%)	n/a	n/a	(0.8%)	(0.4%)	**(4.3%)**
Lumenos w/ Maternity	(6.1%)	n/a	(1.8%)	(0.1%)	n/a	**(8.0%)**
Lumenos w/o Maternity	(6.0%)	n/a	(1.8%)	(0.3%)	n/a	**(8.1%)**
3500 Deductible Plans	(5.3%)	(0.5%)	(2.2%)	(0.8%)	n/a	**(8.3%)**
PPO Share (CDI)	(3.2%)	(1.1%)	n/a	(1.0%)	(0.6%)	**(5.7%)**
PPO Saver	n/a	n/a	n/a	n/a	n/a	**n/a**
Basic Hospital Plans	n/a	n/a	n/a	n/a	n/a	**n/a**
ClearProtection	n/a	n/a	n/a	n/a	n/a	**n/a**
CoreGuard	n/a	n/a	n/a	n/a	n/a	**n/a**
Premier	n/a	n/a	n/a	n/a	n/a	**n/a**
Total	**(2.4%)**	**(0.4%)**	**(0.5%)**	**(0.9%)**	**(0.3%)**	**(4.4%)**

Proposed Benefit Reductions:

A. Increase Deductibles by 19%
B. Increase Brand/Specialty Drug Copays and Deductibles by 19%
C. Utilize Generic Premium Formulary
D. Increase Coinsurance Max by 19%
E. Increase Office Copays by 19%

[(1)] Benefit impacts are not multiplicative as there are dependencies between benefit changes; totals take into account these interdependencies.

DISTRIBUTION OF MEMBERS BY ANNIVERSARY MONTH

	Smart Sense	Basic Hospital Plans	PPO Share (CDI)	3500 Deductible Plans	Right Plan	Tonik	Lumenos w/o Maternity	PPO Saver	Lumenos w/Maternity	Clear Protection	Core Guard	Premier
Apr-2011	46.7%	100.0%	95.0%	67.0%	90.4%	74.7%	54.5%	92.2%	36.4%	8.6%	24.4%	20.1%
May-2011	7.5%	0.0%	0.9%	3.1%	1.7%	4.1%	6.7%	1.3%	8.3%	8.7%	4.2%	9.0%
Jun-2011	8.4%	0.0%	0.9%	3.1%	1.7%	4.5%	7.6%	1.3%	8.4%	9.8%	4.4%	11.9%
Jul-2011	10.3%	0.0%	1.0%	3.4%	1.9%	5.3%	11.0%	1.5%	24.5%	11.3%	16.5%	13.3%
Aug-2011	12.5%	0.0%	0.9%	3.5%	1.9%	5.5%	11.5%	1.6%	13.7%	14.3%	17.1%	17.5%
Sep-2011	10.3%	0.0%	1.2%	7.5%	2.4%	5.8%	8.7%	1.9%	8.7%	25.2%	33.4%	28.1%
Oct-2011	0.5%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nov-2011	0.5%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dec-2011	0.5%	0.0%	0.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Jan-2012	0.6%	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Feb-2012	0.7%	0.0%	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.7%	0.0%	0.0%
Mar-2012	0.8%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	8.8%	0.0%	0.0%
Apr-2012	0.7%	0.0%	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.5%	0.0%	0.0%
Future Years												
Apr	47.3%	100.0%	95.0%	69.0%	90.4%	74.7%	54.5%	92.2%	36.4%	18.1%	24.4%	20.1%
May	7.5%	0.0%	0.9%	3.1%	1.7%	4.1%	6.7%	1.3%	8.3%	8.7%	4.2%	9.0%
Jun	8.4%	0.0%	0.9%	3.1%	1.7%	4.5%	7.6%	1.3%	8.4%	9.8%	4.4%	11.9%
Jul	10.3%	0.0%	1.0%	3.4%	1.9%	5.3%	11.0%	1.5%	24.5%	11.3%	16.5%	13.3%
Aug	12.5%	0.0%	0.9%	3.5%	1.9%	5.5%	11.5%	1.6%	13.7%	14.3%	17.1%	17.5%
Sep	10.3%	0.0%	1.2%	7.5%	2.4%	5.8%	8.7%	1.9%	8.7%	25.2%	33.4%	28.1%
Oct	0.5%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nov	0.5%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dec	0.5%	0.0%	0.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Jan	0.6%	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Feb	0.7%	0.0%	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.7%	0.0%	0.0%
Mar	0.8%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	8.8%	0.0%	0.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

RATE DEVELOPMENT PROCESS

[1]Steps 1 thru 23 excl Dental/Vision; Steps 24 & 25 adjusted to include Dental/Vision

Experience Period: 7/1/2009 - 6/30/2010 Rating Period: 4/1/2011 - 2/28/2013	SmartSense	Basic Hospital Plans	PPO Share (CDI)	3500 Deductible Plans	Right Plan	Tonik[1]	Lumenos w/o Maternity
1. Member Months	2,155,564	1,251,699	1,107,300	1,057,223	693,586	488,800	274,795
2. Actual Premium	$283,514,714	$168,634,669	$245,848,421	$151,635,857	$139,525,033	$68,727,237	$40,318,074
3. Estimated Incurred Claims	$198,452,208	$92,926,642	$213,587,881	$108,784,219	$114,911,095	$50,018,057	$24,553,292
4. Current Loss Ratio	70.0%	55.1%	86.9%	71.7%	82.4%	72.8%	60.9%
5. Current Claims PMPM	$92.07	$74.24	$192.89	$102.90	$165.68	$102.33	$89.35
6. Adjusted Claims PMPM[2]	$92.07	$74.24	$192.89	$102.90	$165.68	$102.33	$89.35
7. Midpoint of Exper Period	1/9/2010	12/28/2009	12/21/2009	12/31/2009	12/25/2009	12/27/2009	1/14/2010
8. Prem at Current Rates PMPM	$158.54	$147.22	$253.16	$156.34	$231.93	$162.39	$170.10
9. Annual Claims Trend	15.9%	15.9%	17.7%	17.4%	14.9%	16.4%	17.1%
10. Midpoint of Rating Period	11/8/2011	9/23/2011	9/23/2011	11/5/2011	9/26/2011	10/9/2011	11/2/2011
11. Months of Trend	21.94	20.84	21.05	22.17	21.03	21.38	21.58
12. Change in Clms Duration Factor	0.18	0.13	0.12	0.23	0.19	0.19	0.36
13. Change in Plan Mix Factor (Claims)	(0.02)	(0.00)	0.00	(0.00)	(0.00)	(0.01)	(0.01)
14. Change in Seasonality Factor	0.01	(0.00)	(0.00)	0.00	(0.00)	0.00	0.01
15. Benefit changes: ACA and "Other"	(2.3%)	0.5%	(5.5%)	(7.5%)	(2.6%)	(3.6%)	(7.5%)
16. Cumulative Trend	31.1%	29.2%	33.0%	34.5%	27.6%	31.1%	32.8%
17. Rating Period Claims PMPM	$137.87	$109.13	$271.56	$157.69	$245.49	$152.79	$150.60
18. Change in Prem Duration Factor	0.08	0.06	0.09	0.11	0.10	0.08	0.10
19. Change in Plan Mix Factor (Prem)	(0.04)	(0.00)	0.00	(0.00)	(0.00)	(0.03)	(0.01)
20. Adj'd Prem at Current Rates PMPM	$164.29	$155.84	$275.40	$173.30	$254.70	$171.19	$184.87
21. Target Loss Ratio	73.8%	83.2%	83.2%	78.6%	83.2%	79.5%	74.8%
22. Required Premium PMPM	$186.92	$131.16	$326.40	$200.65	$295.06	$192.24	$201.34
23. Required Rate Change	13.8%	(15.8%)	18.5%	15.8%	15.8%	12.3%	8.9%
24. Proposed Rate Change (w/ benefit changes)	12.7%	(9.2%)	14.2%	12.7%	14.2%	10.3%	7.8%
25. Proposed Rate Change (w/o benefit changes)	15.3%	(9.6%)	20.8%	21.9%	17.3%	14.4%	16.6%
26. Expected CY 2011 Loss Ratio	76.9%	72.5%	87.4%	82.9%	85.1%	80.5%	74.6%

RATE DEVELOPMENT PROCESS

[2]CoreGuard and Premier have no credible experience data; used SmartSense adjusted for claim duration, benefits, seasonality, & trend midpoint

Experience Period: 7/1/2009 - 6/30/2010
Rating Period: 4/1/2011 - 2/28/2013

	PPO Saver	Lumenos w/Maternity	Clear Protection	CoreGuard[2]	Premier[2]
1. Member Months	176,142	110,414	32,097	19,235	3,057
2. Actual Premium	$34,972,370	$20,035,186	$3,780,758	$2,644,938	$546,616
3. Estimated Incurred Claims	$29,338,480	$31,424,578	$1,492,774	$828,921	$282,403
4. Current Loss Ratio	83.9%	156.8%	39.5%	31.3%	51.7%
5. Current Claims PMPM	$166.56	$284.61	$46.51	$43.09	$92.39
6. Adjusted Claims PMPM[2]	$166.56	$284.61	$46.51	$60.15	$85.22
7. Midpoint of Exper Period	12/27/2009	1/3/2010	5/11/2010	4/22/2010	5/28/2010
8. Prem at Current Rates PMPM	$227.10	$206.63	$117.41	$150.58	$188.92
9. Annual Claims Trend	15.7%	17.1%	17.0%	18.7%	16.7%
10. Midpoint of Rating Period	9/26/2011	11/12/2011	1/10/2012	12/10/2011	12/6/2011
11. Months of Trend	20.97	22.27	20.02	19.62	18.28
12. Change in Clms Duration Factor	0.11	0.24	0.45	0.41	0.49
13. Change in Plan Mix Factor (Claims)	0.00	(0.04)	(0.00)	0.01	0.00
14. Change in Seasonality Factor	(0.00)	0.01	0.03	0.05	0.02
15. Benefit changes: ACA and "Other"	0.6%	(7.6%)	8.5%	4.3%	7.3%
16. Cumulative Trend	29.0%	34.0%	29.9%	32.3%	26.5%
17. Rating Period Claims PMPM	$240.55	$422.40	$98.08	$124.51	$175.35
18. Change in Prem Duration Factor	0.08	0.14	0.07	0.07	0.06
19. Change in Plan Mix Factor (Prem)	0.00	(0.10)	(0.01)	0.02	0.00
20. Adj'd Prem at Current Rates PMPM	$244.84	$212.46	$124.63	$164.28	$200.54
21. Target Loss Ratio	83.2%	83.2%	72.6%	72.6%	72.4%
22. Required Premium PMPM	$289.12	$507.69	$135.15	$171.47	$242.07
23. Required Rate Change	18.1%	139.0%	8.4%	4.4%	20.7%
24. Proposed Rate Change (w/ benefit changes)	13.4%	14.1%	7.8%	3.3%	14.2%
25. Proposed Rate Change (w/o benefit changes)	12.7%	23.5%	(0.6%)	(1.0%)	6.4%
26. Expected CY 2011 Loss Ratio	86.6%	177.3%	68.9%	70.0%	75.6%

LEVERAGED MEDICAL TREND PROJECTIONS FOR LIFETIME MLR MODEL

CY	Smart Sense	Basic Hospital Plans	PPO Share (CDI)	3500 Deductible Plans	Right Plan	Tonik[1]	Lumenos w/o Maternity	PPO Saver	Lumenos w/Maternity	Clear Protection	Core Guard	Premier
2010	16.5%	16.3%	18.2%	17.9%	15.4%	16.9%	17.6%	16.1%	17.6%	17.7%	19.4%	17.4%
2011	15.4%	15.3%	17.0%	16.8%	14.4%	15.9%	16.5%	15.1%	16.5%	16.6%	18.2%	16.3%
2012	14.4%	14.3%	15.9%	15.7%	13.5%	14.8%	15.4%	14.1%	15.4%	15.5%	17.0%	15.2%
2013	13.4%	13.3%	14.8%	14.6%	12.5%	13.8%	14.3%	13.1%	14.3%	14.4%	15.8%	14.1%
2014	12.3%	12.3%	13.6%	13.5%	11.5%	12.7%	13.2%	12.1%	13.2%	13.3%	14.6%	13.0%
2015	11.3%	11.2%	12.5%	12.3%	10.6%	11.6%	12.1%	11.1%	12.1%	12.2%	13.3%	12.0%
2016	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2017	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2018	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2019	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2020	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2021	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2022	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2023	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2024	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
2025	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%

[1] Excludes Dental/Vision Claims, which are trended at 8% throughout the projection period

RATE CHANGE ASSUMPTIONS FOR LIFETIME MLR MODEL

Date	Smart Sense	Basic Hospital Plans	PPO Share (CDI)	3500 Deductible Plans	Right Plan	Tonik	Lumenos w/o Maternity	PPO Saver	Lumenos w/Maternity	Clear Protection	Core Guard	Premier
Oct-2010	14.2%	0.0%	13.8%	9.4%	13.5%	15.1%	12.5%	12.8%	15.1%	0.0%	0.0%	0.0%
Jan-2011	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.0%	0.0%
Apr-2011	12.7%	(9.2%)	14.2%	12.7%	14.2%	11.1%	7.8%	13.4%	14.1%	7.8%	3.3%	14.2%
Apr-2012	14.4%	5.0%	15.9%	15.7%	13.5%	14.8%	15.4%	14.1%	15.4%	15.5%	17.0%	15.2%
Apr-2013	13.4%	13.3%	14.8%	14.6%	12.5%	13.8%	14.3%	13.1%	14.3%	14.4%	15.8%	14.1%
Apr-2014	12.3%	12.3%	13.6%	13.5%	11.5%	12.7%	13.2%	12.1%	13.2%	13.3%	14.6%	13.0%
Apr-2015	11.3%	11.2%	12.5%	12.3%	10.6%	11.6%	12.1%	11.1%	12.1%	12.2%	13.3%	12.0%
Apr-2016	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2017	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2018	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2019	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2020	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2021	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2022	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2023	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2024	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%
Apr-2025	10.3%	10.2%	11.4%	11.2%	9.6%	10.6%	11.0%	10.1%	11.0%	11.1%	12.1%	10.9%

CALENDAR YEAR MLR PROJECTIONS FOR LIFETIME LLR MODEL

CY	Smart Sense	Basic Hospital Plans	PPO Share (CDI)	3500 Deductible Plans	Right Plan	Tonik[1]	Lumenos w/o Maternity	PPO Saver	Lumenos w/ Maternity	Clear Protection	Core Guard	Premier
1999	N/A	43.5%	97.1%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2000	N/A	32.7%	75.5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2001	N/A	71.4%	142.9%	N/A	N/A	N/A	N/A	56.8%	N/A	N/A	N/A	N/A
2002	N/A	63.9%	85.1%	N/A	N/A	N/A	N/A	90.0%	N/A	N/A	N/A	N/A
2003	N/A	56.8%	75.5%	N/A	35.5%	N/A	N/A	61.9%	N/A	N/A	N/A	N/A
2004	N/A	48.5%	75.4%	44.7%	101.8%	26.0%	N/A	84.5%	N/A	N/A	N/A	N/A
2005	N/A	52.7%	68.3%	47.6%	86.0%	112.7%	N/A	72.8%	N/A	N/A	N/A	N/A
2006	N/A	52.2%	65.9%	55.6%	75.4%	83.5%	N/A	72.9%	N/A	N/A	N/A	N/A
2007	56.1%	48.6%	68.8%	57.8%	66.3%	76.2%	266.9%	61.0%	60.1%	N/A	N/A	N/A
2008	60.4%	54.6%	71.3%	61.7%	69.3%	63.5%	51.2%	58.9%	117.8%	N/A	N/A	N/A
2009	66.3%	58.8%	80.0%	67.5%	71.9%	67.9%	60.0%	76.6%	144.1%	N/A	N/A	N/A
2010	78.2%	58.2%	94.5%	78.9%	92.2%	78.3%	69.5%	90.3%	171.4%	51.2%	52.3%	59.8%
2011	76.9%	72.5%	87.4%	82.9%	85.1%	79.1%	74.6%	86.6%	177.3%	68.9%	70.0%	75.6%
2012	76.9%	85.4%	87.5%	82.3%	86.8%	82.5%	76.8%	88.1%	175.5%	73.0%	73.9%	77.5%
2013	81.0%	89.2%	88.5%	83.5%	88.9%	85.9%	78.8%	89.4%	178.6%	75.1%	76.3%	79.7%
2014	86.9%	90.7%	89.3%	84.6%	90.8%	88.5%	81.8%	90.7%	183.0%	79.2%	80.9%	83.9%
2015	91.9%	90.8%	89.5%	85.2%	92.1%	90.4%	84.2%	91.7%	184.4%	85.9%	88.1%	90.8%
2016	93.3%	91.0%	89.6%	85.0%	92.5%	91.2%	84.1%	92.1%	184.2%	91.4%	93.1%	97.1%
2017	92.1%	91.3%	89.6%	84.4%	92.2%	90.8%	82.7%	91.8%	184.1%	90.9%	91.3%	97.3%
2018	91.7%	91.4%	89.6%	84.2%	92.1%	90.6%	82.3%	91.7%	184.1%	89.3%	90.3%	95.2%
2019	91.7%	91.4%	89.6%	84.2%	92.1%	90.7%	82.3%	91.7%	184.1%	89.3%	90.3%	95.2%
2020	91.7%	91.4%	89.6%	84.2%	92.1%	90.7%	82.3%	91.7%	184.0%	89.3%	90.3%	95.3%
2021	91.7%	91.4%	89.6%	84.2%	92.1%	90.7%	82.3%	91.7%	184.0%	89.2%	90.3%	95.2%
2022	91.7%	91.4%	89.6%	84.2%	92.1%	90.7%	82.3%	91.7%	184.0%	89.2%	90.3%	95.2%
2023	91.7%	91.4%	89.6%	84.2%	92.1%	90.7%	82.3%	91.7%	184.0%	89.2%	90.3%	95.2%
2024	91.7%	91.4%	89.6%	84.2%	92.1%	90.8%	82.3%	91.7%	184.0%	89.2%	90.3%	95.2%
2025	91.7%	91.4%	89.6%	84.2%	92.1%	90.8%	82.3%	91.7%	184.0%	89.2%	90.3%	95.2%

Future LLR	84.2%	88.7%	88.6%	84.1%	89.0%	86.2%	80.8%	89.7%	180.9%	79.5%	80.8%	84.7%
Lifetime LLR	79.3%	70.8%	80.5%	77.5%	80.9%	77.5%	76.9%	78.6%	165.1%	73.5%	74.2%	80.2%

[1] Includes Dental/Vision Claims

COMPLIANCE WITH ACA 80% MINIMUM LOSS RATIO: CALENDAR YEAR 2011

	Closed Block[(1)]	New PPACA Plans	Other: HIPAA/ Conversion/Short Term	Anthem BCL&H Total	ACA Adjustments	**ACA-Adjusted**
Member Months	**5,761,877**	1,072,957	66,450	6,901,284		**6,901,284**
Premium	**$1,112,094,144**	$202,068,756	$32,916,700	$1,347,079,600	($42,702,423)	**$1,304,377,177**
Claims	**$910,531,041**	$95,862,781	$36,575,555	$1,042,969,377	$19,397,946	**$1,062,367,323**
Medical Loss Ratio	**81.9%**	47.4%	111.1%	77.4%	**Compliance Test:**	**81.4%**

Med Mgmt Exp (% of prem added to Claims): 1.44%

Prem Tax, FIT and Payroll Tax (% of prem subtracted from Premium): 3.17%

(1) Includes Tonic's Dental & Vision Benefits

Projection of Experience for Anthem BCL&H (for comparison w/PPACA 80% standard)

	Closed Block			
Month	Member Months	Premium PMPM	Claims PMPM	Unadjusted MLR
Jan-10	622,569	$160	$111	69.0%
Feb-10	624,534	$161	$95	59.0%
Mar-10	617,628	$159	$122	77.2%
Apr-10	618,696	$158	$123	77.7%
May-10	620,513	$157	$114	72.7%
Jun-10	622,860	$157	$134	85.5%
Jul-10	625,409	$156	$137	87.8%
Aug-10	630,019	$156	$128	82.4%
Sep-10	638,681	$155	$134	86.4%
Oct-10	633,256	$167	$153	91.2%
Nov-10	615,998	$172	$149	86.7%
Dec-10	594,387	$173	$164	94.8%
Jan-11	573,899	$175	$130	74.5%
Feb-11	554,307	$177	$120	68.1%
Mar-11	535,574	$178	$147	82.5%
Apr-11	517,642	$192	$141	73.5%
May-11	500,474	$194	$148	76.3%
Jun-11	484,035	$196	$159	81.4%
Jul-11	468,290	$198	$172	86.6%
Aug-11	453,216	$201	$161	80.0%
Sep-11	438,775	$204	$168	82.5%
Oct-11	424,954	$205	$192	93.9%
Nov-11	411,709	$206	$186	90.6%
Dec-11	399,002	$206	$203	98.2%
CY 2010	7,464,548	$161	$130	81.0%
CY 2011	5,761,877	$193	$158	81.9%

	New PPACA Plans			
Month	Member Months	Premium PMPM	Claims PMPM	Unadjusted MLR
Jan-10	0	n/a	n/a	n/a
Feb-10	0	n/a	n/a	n/a
Mar-10	0	n/a	n/a	n/a
Apr-10	0	n/a	n/a	n/a
May-10	0	n/a	n/a	n/a
Jun-10	0	n/a	n/a	n/a
Jul-10	0	n/a	n/a	n/a
Aug-10	0	n/a	n/a	n/a
Sep-10	0	n/a	n/a	n/a
Oct-10	0	n/a	n/a	n/a
Nov-10	0	n/a	n/a	n/a
Dec-10	0	n/a	n/a	n/a
Jan-11	16,289	$183	$71	38.5%
Feb-11	31,689	$183	$80	43.7%
Mar-11	46,334	$183	$77	42.1%
Apr-11	60,273	$183	$85	46.2%
May-11	73,620	$185	$72	39.1%
Jun-11	86,400	$186	$68	36.4%
Jul-11	98,643	$186	$83	44.6%
Aug-11	110,371	$188	$84	44.8%
Sep-11	121,611	$189	$90	47.6%
Oct-11	132,386	$190	$99	51.8%
Nov-11	142,716	$192	$107	56.1%
Dec-11	152,625	$193	$102	52.7%
CY 2010	0	n/a	n/a	n/a
CY 2011	1,072,957	$188	$89	47.4%

Projection of Experience for Anthem BCL&H (for comparison w/PPACA 80% standard)

	Other: HIPAA/Conversion/Short Term			
Month	Member Months	Premium PMPM	Claims PMPM	Unadjusted MLR
Jan-10	2,080	$263	$273	103.7%
Feb-10	2,182	$283	$207	72.9%
Mar-10	2,319	$318	$614	192.9%
Apr-10	2,524	$342	$335	97.9%
May-10	2,613	$359	$375	104.6%
Jun-10	2,861	$368	$342	93.1%
Jul-10	3,184	$375	$364	97.1%
Aug-10	3,485	$379	$339	89.6%
Sep-10	3,634	$403	$431	107.0%
Oct-10	3,881	$407	$482	118.3%
Nov-10	4,224	$399	$454	113.7%
Dec-10	4,484	$405	$397	97.9%
Jan-11	4,679	$414	$465	112.3%
Feb-11	4,784	$428	$486	113.5%
Mar-11	4,894	$441	$506	114.8%
Apr-11	5,008	$453	$525	115.9%
May-11	5,203	$459	$536	116.9%
Jun-11	5,398	$512	$547	106.8%
Jul-11	5,593	$518	$557	107.6%
Aug-11	5,788	$523	$567	108.4%
Sep-11	5,983	$528	$577	109.2%
Oct-11	6,178	$533	$586	110.0%
Nov-11	6,373	$537	$595	110.8%
Dec-11	6,568	$541	$604	111.6%
CY 2010	37,469	$369	$393	106.5%
CY 2011	66,450	$495	$550	111.1%

	Anthem BCL&H Total			
Month	Member Months	Premium PMPM	Claims PMPM	Unadjusted MLR
Jan-10	624,649	$161	$111	69.2%
Feb-10	626,715	$161	$95	59.1%
Mar-10	619,947	$159	$124	78.1%
Apr-10	621,220	$159	$123	77.9%
May-10	623,125	$158	$115	73.0%
Jun-10	625,720	$158	$135	85.6%
Jul-10	628,592	$157	$138	87.9%
Aug-10	633,503	$157	$130	82.5%
Sep-10	642,315	$156	$135	86.7%
Oct-10	637,137	$169	$155	91.6%
Nov-10	620,221	$174	$151	87.1%
Dec-10	598,870	$175	$166	94.9%
Jan-11	594,867	$177	$131	74.1%
Feb-11	590,780	$179	$121	67.7%
Mar-11	586,803	$181	$145	79.9%
Apr-11	582,924	$193	$138	71.7%
May-11	579,297	$195	$142	72.7%
Jun-11	575,832	$197	$149	75.7%
Jul-11	572,526	$199	$160	80.3%
Aug-11	569,376	$202	$150	74.4%
Sep-11	566,369	$204	$156	76.3%
Oct-11	563,518	$205	$175	85.2%
Nov-11	560,798	$206	$171	83.0%
Dec-11	558,195	$207	$180	87.0%
CY 2010	7,502,017	$162	$132	81.3%
CY 2011	6,901,284	$195	$151	77.4%

Attachment 19

Anthem Blue Cross Life & Health Insurance Company

Return on Equity

($ in millions)

	Annual Stmt Ref	2008 Actual	2009 Actual	2010 Prelim	2011 Forecast
Statutory Net Income	IS L32	194.5	170.5	205.9	183.5
Statutory Capital & Surplus	BS L31	760.1	813.8	973.8	1,082.9
Return on Equity		25.6%	21.0%	21.1%	16.9%

Notes:

2) 2008-2010 Statutory info from indicated exhibit/schedule in Statutory annual statement.
3) 2010 Statutory amounts are preliminary as the 2010 annual statement has not yet been filed.
4) 2011 Statutory amounts from projections provided to CA CDI on October 20, 2010.

SUPPLEMENTAL COMPENSATION EXHIBIT

Attachment 20A

2009 DOI (BLANK FILING)

Anthem Blue Cross Life and Health Insurance Company

OFFICERS AND EMPLOYEES

	1 Name and Principal Position	2 Year	Annual Compensation 3 Salary	4 Bonus	5 All Other Compensation(1)	6 Totals
1	Wayne S. DeVeydt					
	Chief Financial Officer					
2	Leslie A. Margolin (2)					
	Chief Executive Officer					
3	R. David Kretschmer					
	Treasurer					
4	Nicholas L. Brecker, III					
	President					
5	Kathleen S. Kiefer (3)					
	Secretary					
6	G. Lewis Chartrand					
	Assistant Secretary					
7	(4)					
8						
9						
10						

The reporting insurer is a member of a group of insurers or other holding company system. The above amounts represent compensation paid to each individual by or on behalf of all companies which are part of the group. The total compensation (column 6) is the amount reported in the year-end W2 gross taxable wages.

1 Amounts earned in All Other Compensation (column 5) may include payouts earned under multi-year long term incentive plans, sales incentives, and the exercise of stock options granted in prior years.

2 Leslie A. Margolin was hired January 28, 2008.

3 Kathleen S. Kiefer became Secretary on March 9, 2009.

4 There are no employees dedicated to Anthem Blue Cross Life and Health Insurance Company. Data has been reported for officer

SUPPLEMENTAL COMPENSATION EXHIBIT

Attachment 20B

2009 DOI (BLANK FILING)

Anthem Blue Cross Life and Health Insurance Company

DIRECTORS

1 Name and Principal Position or Occupation	2 Compensation Paid or Deferred for Services as Director	3 All Other Compensation Paid or Deferred	4 Totals
1 None - Internal Directors do not receive compensation in their capacity as a Director.		--	$0
2		--	$0
3		--	$0
4		--	$0
5		--	$0
6		--	$0
7		--	$0
8		--	$0
9		--	$0
10		--	$0
11		--	$0
12		--	$0
13		--	$0
14		--	$0
15		--	$0
16		--	$0
17		--	$0

1. Inside (i.e., employee) directors are not compensated for serving on the Board of Directors.

Unadjusted Medical Care CPI for All Urban Consumers

Source: Bureau of Labor Statistics; http://www.bls.gov/cpi/#tables
Rolling 12-mth Trends at End of Year

End of Year	Rolling 12-month CPI Trend
1981	10.8%
1982	11.6%
1983	8.7%
1984	6.2%
1985	6.2%
1986	7.5%
1987	6.6%
1988	6.5%
1989	7.7%
1990	9.1%
1991	8.7%
1992	7.4%
1993	6.0%
1994	4.8%
1995	4.5%
1996	3.5%
1997	2.8%
1998	3.2%
1999	3.5%
2000	4.1%
2001	4.6%
2002	4.7%
2003	4.0%
2004	4.4%
2005	4.2%
2006	4.0%
2007	4.4%
2008	3.7%
2009	3.2%
2010	3.4%

From: Bureau of Labor Statistics Website:
http://www.bls.gov/cpi/cpifact4.htm
For the medical care categories the CE collects information on household out-of-pocket expenses. These may include data such as healthcare services received, who received it, the amount of payment made, and insurance reimbursements received. Medical care expenditures eligible for the CPI include out-of-pocket expenses paid by the consumer. These include fees (not recouped through health insurance) that consumers paid directly to retail outlets for medical goods and to doctors and other medical providers for medical services, as well as health insurance premiums that consumers paid (including Medicare Part B). To arrive at the consumer out-of-pocket medical expense, the CE nets out direct insurance reimbursements to the consumer from the total amounts paid by the consumer.

Since medical care only includes consumers' out-of-pocket expenditures (and excludes employer provided health care), its share in the CPI is smaller than its share of gross domestic product (GDP) and other national accounts measures.

STATE OF CALIFORNIA
Dave Jones, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
Legal Division
45 Fremont Street, 24th Floor
San Francisco CA 94105

Guidance 1163: 2

Draft release date: February 3, 2011
Final release date: _____

Pursuant to Senate Bill 1163 (Chapter 661, Statutes 2010), the California Department of Insurance issues the following guidance regarding compliance. [1] Further guidance may be forthcoming in the future.

Section A: Unreasonable Rate Increases

For all health insurance filings, for the purpose of the actuarial certification required under Insurance Code section 10181.6(b)(2) and review under Insurance Code section 10181.11, as well as for the filing of large group health insurance rates under section 10181.4, the factors the Department will consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the following:

1) The relationship of the projected aggregate medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law. See interim final rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," (45 C.F.R. sections 158.101- 158.232, 75 Fed. Reg. 74921-74928, (December 1, 2010)), incorporated herein by reference.

2) Whether the assumptions on which the rate increase is based are supported by substantial evidence.

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[1] Senate Bill 1163 provides, at Insurance Code section 10181.2, that Article 4.5 (Insurance Code section 10181 *et seq.*) does not

> apply to a specialized health insurance policy; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health insurance policy offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

Accordingly, the above guidance does not apply to the types of insurance listed in Insurance Code section 10181.2.

3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is reasonable.

4) Whether the data or documentation provided to the Department in connection with the filed rate increase is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of the rate may be determined.

5) Whether the filed rates result in premium differences between insureds within similar risk categories that:

(A) Are otherwise not permissible under applicable California law; or
(B) Do not reasonably correspond to differences in expected costs.

6) Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible experience data.

7) The company's rate of return, evaluated on a return-on-equity basis, for the prior three years, and anticipated rate of return for the following year, taking into account investment income.

8) The insurer's employee and executive compensation.

9) The degree to which the increase exceeds the rate of medical cost inflation as reported by the U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index.

10) For individual policies, whether the proposed rates comply with California Code of Regulations Title 10, section 2222.12.

Section B: Filing and Notice

11) For individual and small group health insurance policies, rate submissions for new products and rate increases for existing products must be filed at least 60 days prior to implementation. (Insurance Code section 10181.3(a), (b)(14).)

12) The filing requirements of Senate Bill 1163 (Insurance Code sections 10181.3, 10181.4, 10181.6, 10181.7) apply to new product rates and rate increases implemented on or after January 1, 2011. With respect to rate filings submitted to the department prior to January 1, 2011 that include rate changes which will be implemented as to any insureds after January 1, 2011, the insurer must provide the 60-day notice described in Insurance Code section 10113.9 or 10199.1 for those changes.

13) The consumer notice required by Insurance Code section 10113.9 or 10199.1 must be delivered concurrently with the submission of the rate filing to the department. The notice required by section 10113.9 must include the date on which the proposed rate increase will be applied to the individual(s) to whom the notice is addressed. If a rate filing is revised after its initial submission so as to change the rates, an additional 60-day notice meeting

the requirements of Insurance Code sections10113.9 or 10199.1 must be provided reflecting the revised rate.

Section C: Actuarial Certification

14) (A) The certification required under Insurance Code section 10181.6 (b)(2) is a "Statement of Actuarial Opinion," as defined in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, promulgated by the American Academy of Actuaries. Such a certification is also a "Health Filing," as defined in Actuarial Standard of Practice No. 8 promulgated by the Actuarial Standards Board, and it is also an "Actuarial Communication," as defined in Actuarial Standard of Practice No. 41 promulgated by the Actuarial Standards Board.

(B) The certification required under Insurance Code section 10181.6 (b)(2) must include the following information:

(1) A statement of the qualifications of the actuary issuing the certification. The actuary's qualifications must meet the standards stated in *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*. The statement of qualifications must include a statement that the actuary meets the independence requirements stated in Insurance Code section 10181.6 (b)(3).

(2) A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate. Premium rates are actuarially sound if, for business in California and for the period covered by the certification, the total of projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income is adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of required capital.

(3) For each contract or insurance policy included in the filing, a complete description of the data, assumptions, rating factors, and methods used to determine the premium rates, with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract or policy form included in the filing.

(4) A statement of opinion, with respect to each individual or small group rate increase included in the filing, whether the rate increase filed is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies, including benefit relativities that reflect the expected variations in cost, taking into consideration historical experience and the credibility of the historical data. Statements of opinion regarding whether a rate increase is reasonable or unreasonable shall discuss the factors listed in Section A, "Unreasonable Rate Increases," of this Guidance. In addition, statements of opinion regarding individual health insurance shall discuss whether the benefits

provided under the policy are reasonable in relation to the premium charged, as described in California Code of Regulations title 10, chapter 5, section 2222.10, *et seq*.

(5) A description of the testing performed by the actuary to arrive at the statements of opinion in paragraphs (B)(2) and (B)(4) above, including any independent rating models and rating factors utilized.

(C) All of the information required in (B), above, must be contained within the actuarial certification. A separate actuarial memorandum should not be submitted.

Section D: Filing Requirements

15) Individual and small group health insurance rate filings must be accompanied by the "California Rate Filing Form" that discloses the information required by Insurance Code section 10181.3(b), submitted as a PDF document under the "Supporting Documentation" tab in SERFF. See "California Rate Filing Form" on the Department's website (http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm) for definitions of certain of the items required.

16) All health insurance rate filings must be accompanied by the "California Plain-Language Rate Filing Description", submitted as a PDF document under the "Supporting Documentation" tab in SERFF (Insurance Code section 10181.7(d)). See "California Plain-Language Rate Filing Description" on the Department's website (http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm) for the form and format of the items required.

17) The aggregate rate filing data report required by Insurance Code section 10181.3(c) need not be submitted with each separate rate filing but must be filed with the Department at least quarterly (no later than 5 calendar days after the end of the calendar quarter). Each such report must summarize the required data for the calendar quarter, as well as for the calendar year to date. The report should be identified in SERFF by placing "Aggregate Rate Filing Date Report" in the "Filing Description" field under the "General Information" tab. A form for this report will be provided in subsequent guidance. The terms "Segment Type", "Product Type", and "average rate increase" will be defined as they are in the attached "California Rate Filing Form" for items 5, 4, and 13 respectively.

For questions, please contact Bruce Hinze at bruce.hinze@insurance.ca.gov.
Please submit comments regarding this draft guidance to:
guidancecomments@insurance.ca.gov .

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